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- EDITOR'S NOTE -

This issue of the Exchange contains the papers, or abstracts of papers presented at the First Annual Meeting of the Rorschach Institute, Inc. in section III "Rorschach in Medical Research" on June 22, 1940 at the New York State Psychiatric Institute and Hospital, New York City. This section of the program was arranged, and the editing of this issue was undertaken by Douglas M. Kelley, M.D. of the N.Y. State Psychiatric Institute and Hospital.

ANATOMICAL PERSEVERATION IN RORSCHACH RECORDS

by W.D. Ross, M.D.*

Introduction

The observation that a certain type of performance on the Rorschach test has occurred in my experience in patients with a considerable range of diagnoses, has led to a desire to study its possible significance. This is the type of performance in which the subject gives complete or almost complete perseveration of responses having the content of parts of the body, either anatomical or external.

I can find no reference in the literature to this as a specific entity. Such standard authorities as Rorschach, (1) Oberholzer (2) (3), Klopfer (4), and Beck (5) discuss the meaning of the occurrence of a high number of anatomical answers, or anatomical stereotypy, and other writers have discussed the meaning of this tendency in special papers (6), (7), (8). This is not, however, the same thing as complete or almost complete perseveration of these responses. In the latter the patient appears to be handicapping his total performance through a limitation of the field of content. It is possible that he might give a very different record if he were not reacting within the bounds of such a self-imposed limitation, particularly since the responses in this content give no scope for the movement determinants. In high anatomical stereotypy without perseveration, however, the presence of several responses of other content indicates that the subject is not excluding other reactions.

It has been a common experience to have a patient who has given the anatomical perseveration type of performance say, when reminded at the end of the test that he or she had been given instructions indicating that the blots might be anything at all, "But, doctor, I thought you meant that they would be parts of the body - some of them look like parts of the body so I thought they were all supposed to be that."

This unwarranted jumping to conclusions on the part of the patient is an indication of a mental attitude which interferes with an objective outlook, but nevertheless the tendency to jump to unwarranted conclusions is such a widespread human characteristic that it cannot necessarily be taken as evidence of a neurosis or a cerebral lesion or any single particular psychological characteristic. Hence, the need for distinguishing this performance from the type which has been described as high anatomical stereotypy.

The present work aims to obtain evidence for the meaning of this type of performance through a clinical study of several patients who have given it in comparison with the other patients examined by the author with the Rorschach method over the same period of time.

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Clinical Material

The clinical material from which the cases in this report were obtained includes patients examined over a period of five months at the Montreal Neurological Institute and on the wards and in the outpatient clinics of the Royal Victoria Hospital and the Montreal General Hospital as well as several healthy individuals outside of the hospital environment. Some of the latter were privates in the Royal Army Medical Corps. The selective factor in operation in regard to the patients studied was either the desire of the physician in charge of the case to have a Rorschach test done because of possible personality factors in the illness, or the author's interest in the case as a neurological or psychosomatic problem. These factors have naturally selected a predominant number of cases in which the personality of the individual deviates from normal, but in some of the general medical disorders an attempt was made to get some completely random samples of the condition being studied. The series is representative, at any rate, of the patients likely to be seen when the Rorschach test is applied to Psychosomatic Medicine.

Definitions.

The cases for this report were selected on the basis of the following definitions:

Complete anatomical perseveration is considered to be the type of performance in which the patient gives entirely responses with the content of parts of the body, either internal organs, human details, or X-ray pictures.

Almost complete anatomical perseveration is the type of performance in which all responses are given in such a fashion with the exception of two or three responses in which an easy popular concept is given, such as a bat or butterfly in V, or the side animals in VIII. The reason for the inclusion of this type of performance, although barring anatomical stereotypy of a lesser degree, is that these patients seem to be the victims of a limitation of content even though they release it in obvious places. This is illustrated by a remark which they sometimes make, "Well, that looks like a butterfly, but I can't tell you what parts of the body it represents." One case is included in the almost complete perseveration category in which the subject perseverated the popular "butterfly" from V to VI and VII where it is not a popular response. When occasional exceptions such as this are included along with the definition given above there seems to be a definite distinction between this type of performance and those in which a large number of anatomical answers may be given but there are enough answers of other content to indicate that the patient is not handicapping himself by a content limitation which excludes many of the determinants.

Total Incidence.

On this basis of selection there were found to be 18 cases of complete or almost complete anatomical perseveration in 216 cases studied, or an incidence of 8%. The distribution of these cases in the diagnostic sub-groups is illustrated by Table I.

Discussion of Table I.

A survey of Table I indicates a fairly equitable distribution of these cases among the diagnostic groups as a whole. The first two columns are figures

TABLE I

Diagnosis and grouping	No. of Cases		Main groups and significant individual diagnoses		
	Total At.	Persev.	Total At	Persev.	Incidence
NORMALS	44	3	44	3	7%
Abnormal children	7	1			
Malingerers	2	0			
Uncomplicated psychoneuroses	34	3			
Psychogenic headaches	5	0			
Neurotic with psychotic trend	5	0			
Predominating psychoneurotic symptoms with definite somatic basis	8	0			
Post-traum. symptoms probably neurotic in origin	4	1			
TOTAL CASES WITH PREDOMINANTLY NEUROTIC FEATURES			52	4	8%
Post-traum. cases with neurotic features but probably primary cerebral damage	7	1			
Post-traum. cases due to definite cerebral damage (including post-traum. epilepsy)	5	1			
TOTAL POST-TRAUMATIC			16	3	19%
Cerebral neoplasms	5	0			
C. N. S. Syphilis	5	0			
Multiple sclerosis	4	0			
Parkinsonism	3	2	3	2	66%
Other lesions of C. N. S.	8	0			
TOTAL KNOWN LESIONS OF C. N. S.			30	3	10%
EPILEPTICS of undetermined cause	18	1	18	1	6%
Toxic psychoses	5	1			
Psychoses of unknown etiology (including schizophrenics)	12	0			
TOTAL PSYCHOSES			17	1	6%
Hyperthyroidism	4	1			
Other endocrine disorders	6	1			
Peptic ulcers	11	1			
Colitis	4	1			
Hypertension	7	0			
Miscellaneous somatic disorders (arthritis, asthma, etc.)	6	0			
TOTAL GENERAL MEDICAL			38	4	10%
Miscellaneous neurological syndromes and diseases (Migraine, Tic douloureux, Menieres, myasthenia gravis, etc.	11	0			

for all the cases studied with the number of anatomical perseveration performances given for each diagnosis. The last three columns indicate a re-grouping of some of the diagnoses into normals, neurotics, post-traumatics, C.N.S. lesions, epileptics, psychotics, and general medical disorders. With the exception of the single diagnosis of Parkinsonism which included two out of three performances of this type, too small a series for any conclusions, and the group of post-traumatic conditions which gave an incidence for this performance of 19%, all the other diagnoses appear to show a random incidence. In each of the main groups other than post-traumatics the incidence runs from 6 - 10% or roughly the same as in the total series. Hence the clinical diagnosis alone gives no clue to the significance of this type of performance.

An examination of the individual patients who gave this reaction in comparison with the other patients in their clinical groups might shed some light.

Discussion of Table II.

Table II is a summary of the individual cases and of the entire group as a whole with certain characteristics noted.

The factors which have been tabulated were chosen for these reasons:

(1) During the course of collecting these records it appeared that many individuals who gave this type of performance had in comparison with most patients in the group as a whole either some language difficulty or some reason for failing to comprehend the nature of the test. Some were individuals of foreign extraction whose comprehension of English was poor (#11, #14, #16); some were French Canadians, with little English, and whose French was a patois which made rapport difficult (#2, #10, #12, #15, #18). A Binet done on one of them (#4) showed an I.Q. of 87, and at least one other (#6) appeared to be of low intelligence on clinical grounds but intelligence tests apart from the Rorschach were not done on most of them.

(2) Although there were no more than average of anatomical perseveration records in the diagnostic group of central nervous system lesions, the fact that some of the individual diagnoses showing a high incidence of these responses were cases having disease of the C.N.S., and the fact that high anatomical stereotypy has been attributed by various authors to "organic" conditions, would suggest that a detailed survey should be made of each individual case for the known presence or absence of clinical evidence of disease of the central nervous system, apart from the primary diagnosis. In computing the figure for this second column for the entire group epileptics and psychoses of unknown etiology were included to assure that all cases with possible disease of the nervous system were taken as a basis for comparison. Among the anatomical perseveration cases one post-traumatic case (#8) is noted as doubtful to negative (∓), because the symptoms were probably neurotic in origin, without any actual damage to the central nervous system. Another post-traumatic case (#9) is noted as doubtful to positive (±), because, although there had been some abnormality of personality previous to the accident, the symptoms at the time of examination were probably due to brain damage. The toxic and endocrine cases are marked separately by a T, because there might be indirect effects of the process on the central nervous system. One of these, in fact, (#16) was a case of diabetes insipidus which might have been due to a lesion in the nervous system. In addition, a comparison is made with the

group as a whole when toxic and endocrine states are grouped with central nervous system lesions.

(3) A study of the individual patients giving anatomical perseveration among the general medical group showed that, in comparison with the other patients having the same diagnoses, they all had some neurotic element, either contributory to their symptoms, or secondary to them. For example, the case of colitis (#18) was diagnosed as "Neurogenic colitis", whereas the case of diabetes insipidus was considered clinically to have a superimposed anxiety neurosis. For this reason the presence or absence of neurotic features in all the individual cases was noted apart from the primary diagnostic classification. Two cases are scored as doubtful (±): one (#4) because the pathological lying which the child displaced may or may not be considered a neurotic characteristic; the other (#15) because although the patient suffered from "nervousness" this was to be expected as a symptom of her primary condition. These two cases are considered as one-half each in computing the total figure. Two cases (#13, #14) are marked with a query (?) because the presence or absence of neurotic features previous to the onset of the illness could not be determined and the illness was such as to mask these features if they existed. These are not included in the total. On the basis of giving the control group <u>every</u> doubtful or masked case so as to prevent loading on the side of the anatomical perseveration cases the total figure for the presence in the entire group of cases with neurotic features was made to include epileptics and psychotics.

(4) After some of these records had been collected (#11 and #12 were obtained first chronologically) it was realized that the performance consisting of anatomical perseveration alone gave an inadequate record for interpretation purposes because of the effects of the limitation of content which have been mentioned. Hence it was decided to employ the routine, whenever complete or almost complete anatomical perseveration was given by a patient, of repeating the test with instructions to the patient to give only answers which did not represent parts of the body. This repetition was done after the first enquiry and before the testing of limits. In order to illustrate the difference in the information obtained by analysis of the original and the repeat performance the incidence of certain Rorschach signs has been scored in the two performances. The signs which have been tabulated are those described by Piotrowski (9) as evidence in favor of disease of the central nervous system, and those designated by Miale and Erickson (10) as indicative of neuroses. It must be mentioned, as the original authors of these signs point out, that these alone are not to be considered a complete basis for a diagnosis from the Rorschach point of view. The qualitative features of the record as a whole must be taken into consideration. The signs are used here, however, as an <u>index</u> of the interpretable features which are obtainable in the initial and in the repeat performances. These signs are tabulated here so that Piotrowski's signs both in the first and second performance stand beside the column indicating the presence or absence clinically of disease of the central nervous system. Likewise with the Miale and Erickson signs in relationship to the presence or absence clinically of neurotic features.

(5) A final tabulation is presented of the presence of complete freedom from either disease of the nervous system or neurotic features, because this criterion of normality in a psychiatric sense, apart from the presence of illness with no obvious psychological implications, might have some significance in relation to the performance under study. Toxic and endocrine condi-

TABLE II

CASE	DIAGNOSIS	Language or comprehension	Clinical evidence of CNS lesion	Piotrowski's "cortical-sub-cortical"		Clinical evidence of neurotic features	Miale & Erickson's "Neurotic signs"		Complete absence of neurosis or CNS lesion
				At. persev. record	2nd record		At. persev. record	2nd record	
1	Normal (R.A.M.C.)			5	1		4	2	+
2*	Normal (R.A.M.C.	+	-	6	2	-	5	3	+
3	Normal (R.A.M.C.)	-	-	5	1	-	5	5	+
4	Child behaviour problem	+	-	4	1	±	3	4	-
5	Functional cardiospasm	-	-	5	3	+	3	4	-
6	Neurasthenia	+	-	6	2	+	4	5	-
7*	Hysteria	-	-	6	2	+	7	5 /	-
8	Post-traum. headache probably neurotic	-	- +	7	3	+	7	7	-
9	Post-traum. delirium probably cerebral damage	-	+ -	7	7	+	4	6	-
10*	Post-traum. delirium definite cerebral damage	+	+	6	5	-	5	4	-
11	Parkinsonism from vascular accident	+	+	7	//	+	4	//	-
12	Post-encephalitic Parkinsonism	+	+	5	//	-	4	//	-
13	Epilepsy with onset age 62	-	+	7	7	?	5	5	-
14	Toxic psychosis	+	T	8	5	?	5	3	T
15*	Hyperthyroidism	+	T	4	5	±	6	5	T
16	Diabetes insipidus	+	T	6	5	+	4	5	-
17	Duodenal ulcer	-	-	8	2	+	7	8	-
18*	"Neurogenic" colitis	+	-	6	3	+	6	4	-
TOTALS	At.persev. group 18	10	5+3T			10			3
	Entire Group 216	34	72+15T	(if toxic and endocrines included with CNS lesions)		121			65
INCIDENCE	At.persev. group	55%	28%	44%		55%			17%
	Entire group	16%	32%	39%		56%			30%
DIFFERENCES		39%	-4%	+5%		-1%			-13%

*Indicates almost complete anatomical perseveration. All the rest were complete anatomical perseveration. / This patient lost color shock & shading shock in the 2nd performance which accounts for the apparent improvement. // These patients were not given the test a 2nd time as they were seen early in the study before this routine was adopted.

tions are again given a separate designation if they contain no evidence of a neurosis or of a C.N.S. lesion apart from indirect effects possible.

Results of Table II.

The results which appear from a study of this table are as follows:

(1) Some language difficulty or difficulty in comprehension was present in 10 out of the 18 cases giving anatomical perseveration, or an incidence of 55% whereas the incidence of this factor in the series as a whole is only 16%. This would suggest that this may be a factor in the production of the anatomical perseveration performance and a possible source of error in drawing conclusions from this type of performance.

(2) The incidence of known disease of the central nervous system in these patients is 28%, compared with an incidence in the entire series of 32%. When toxic states and endocrine disorders are included the incidence is 44% compared with 39% in the total. These figures would give us no basis for concluding that the anatomical perseveration performance is evidence in favor of disease of the central nervous system.

(3) The incidence of cases in which some neurotic features were known to be present clinically is 10 out of 18 or 55%. The incidence of this feature in the entire series being 56% we cannot conclude any special predisposition to neurotic features among the anatomical perseveration group. It must be remembered, however, that this comparison was made with the figure for the entire group including among patients with neurotic features epileptics and psychotics whereas the two patients in the anatomical perseveration series who are classed as epileptic or psychotic were given the benefit of the doubt of being free from neurotic features. If all cases of epileptics of undetermined cause, and of psychotics, are dropped from both groups the incidence of neurotic features in the anatomical perseveration group is 62% compared with 50% in the total which may have a slight significance.

(4) The tabulation of "organic" and "neurotic" signs shows a high incidence of both of these in the anatomical perseveration records. In the repeat records, however, these signs have decreased in many of the cases.

The "organic" signs have decreased markedly except in the cases known clinically to have disease of the central nervous system and in those in which a toxic or endocrine factor was present in which they have decreased slightly.

The "neurotic" signs have not decreased as consistently and in fact they have increased in many of the cases in which neurotic factors were known to be present clinically.

This comparison provides a very striking index of the greater reliability of the repeat performance for interpretation purposes. The high number of neurotic signs present in the second records of most of these patients might also tend to suggest that patients giving this type of performance may have neurotic trends.

(5) When we count the cases in which either disease of the nervous system or a neurotic reaction is completely absent we find 3 cases, or 17%, in the

anatomical perseveration group as compared with 65 cases, or 30% in the entire group. The likelihood that either a central nervous system lesion or a neurotic reaction is present when a patient gives an anatomical perseveration performance is therefore significant although not sufficiently conclusive to base a diagnosis on the presence of this performance alone. The three individuals free from these conditions who gave anatomical perseveration were apparently normal privates in the Royal Army Medical Corps. Whether they have latent neurotic tendencies or any particular psychological characteristics we cannot say at present. Recruits volunteering for the medical corps might have a greater than usual curiosity about medical things, which might be pertinent to the occurrence of anatomical perseveration in 3 of the 21 R.A.M.C. men as compared with none in the 23 other miscellaneous normals.

Discussion in Relation to Literature

A discussion might be presented of these results in relation to the types of patients who have been described in the literature as giving allied types of performances even though this specific type of performance has not previously been differentiated. Beck (5) has stated that perseveration of a response is an index of poverty of thought content in the feeble-minded, and in other clinical groups it is related with the topic of preoccupation or brooding. The present work neither confirms nor disproves this explanation in relation to the specific perseveration of anatomical parts. Mahler-Schoenberger and Silberpfennig (6) attribute high anatomical stereotypy to a narcissistic preoccupation of the subject with his own body. We have no evidence in our work on this specific psychological characteristic. Bleuler (7) attributed a high proportion of these answers to the factor of hospitalization. Three of our patients who gave all anatomical answers were outside of hospital environment although they were members of the Army Medical Corps which might be significant. Dubitscher (8) suggested that a complex in relation to their illness was present in patients giving many anatomical answers, which may or may not be true in our patients. Rorschach (1) mentioned imbeciles, epileptoids, accident neurotics, neurotics and other debiles, particularly hysteroid debiles with a vivid intelligence complex. Oberholzer has made the claim that more than 50% of anatomical answers often occurs in Jacksonian epileptics and other focal lesions such as brain tumors (2) and he has drawn attention to the occurrence of these answers in compensation neuroses (3). These incidences may apply to a high number of anatomical answers but our work does not indicate anatomical perseveration to occur chiefly in these types of patients. This is all the more reason for studying complete or almost complete anatomical perseveration as a separate entity and further studies might be justified as to its possible psychological significance.

General Conclusions.

Apart from conclusions of interest to Rorschach workers some observations of general psychosomatic interest can be noted.

A type of performance on the Rorschach test which may indicate a specific personality tendency has been found in greater number in patients with either some central nervous system lesion or some neurotic reaction than it has been found in other ill patients without these factors manifest clinically. It has also been found in some apparently healthy people. This might indicate a common psychological deviation for people with lesions of the nervous system, and those with the disturbances of its function which come under the clinical label of "neurotic", in comparison with people in whom

illness is manifested in other systems.

A demonstration is given in a few cases of the correspondence between certain Rorschach signs suggestive of central nervous system disease, and of others suggestive of neurosis, with the presence or absence clinically of each of these types of disorder. Certain Rorschach signs present in cases with disease of the nervous system are present to a greater extent in some cases with toxic and endocrine disturbances than they are in other illnesses.

Summary.

Complete or almost complete perseveration in Rorschach records of responses giving the content of parts of body, which has not been described specifically in the literature, has been found among subjects of psychosomatic interest in 18 out of 216 cases, or an incidence of 8%.

These cases included a wide range of diagnoses and one cannot draw conslusions in regard to the diagnosis from this type of performance alone. An analysis of the individual cases giving the reaction suggests that language difficulty or difficulty in comprehending the nature of the test may be a factor in producing this type of performance, and that a patient giving this performance is more likely than not to have either a disease of the central nervous system, or a neurotic reaction either primary or secondary to their illness.

When this type of performance occurs, the test should be readministered to the subject with the request that he find things other than parts of the body. The second performance is a much more reliable basis for interpretation than the initial performance, but both performances should be taken into consideration.

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RORSCHACH STUDIES DURING SODIUM AMYTAL NARCOSES. (abstract)

Douglas M. Kelley, M.D.* and Kate Levine, M.A.

Soon after the introduction of sodium amytal as a therapeutic agent in the psychotic states by Bleckwenn in 1930, numerous workers found that the intravenous injection of this drug in prenarcotic doses produced transient ameliorating effects in certain psychotic patients. The mental changes which resulted were for the most part striking shifts from withdrawn, resistive and uncooperative attitudes to communicative, cooperative and friendly ones. Because of these findings it seemed reasonable to assume that patients who, during the course of a study by means of the Rorschach method refused so many cards that accurate personality description or diagnosis was impossible, might, under the influence of prenarcotic doses of sodium amytal, give a sufficient number of responses to permit an adequate evaluation of the record.

Quantitative findings on 14 cases have been presented in another communication and showed that in all cases which originally rejected five or more cards the use of intravenous sodium amytal produced responses to almost all of the cards in every case. From this point of view it was further shown that quantitatively sodium amytal injections permit the securing of a record containing a satisfactory number of responses in cases otherwise inaccessible to the method.

From a qualitative point of view it is important to know whether the amytal itself produces any marked variation in the response pattern or whether it merely permits an expansion which truly reflects the basic personality of the subject being scrutinized. Qualitative changes do occur in the records but as far as can be determined from our material only as a more complete picture of the patient. This is verified by the fact that in all cases in whom diagnoses before amytal was impossible accurate diagnoses were made under amytal exactly coinciding with the clinical diagnosis of three members of the staff except for two cases in which clinical agreement was not reached.

Work recently reported by Orbison, Eisner and Rapaport tends to show that under sodium amytal there is an increase in the movement and color sum factors. While this may be true to some slight extent the authors do not give sufficient material to substantiate their claims and clinical experience proves that these changes, if present, are certainly not of sufficient proportion to preclude accurate clinical diagnosis. Also work reported in a personal communication by Dr. J. Ewalt of Denver, Colorado substantiates the fact that clinical diagnosis under amytal is not affected by any changes resulting from the action of the amytal itself.

These findings are borne out by the clinical studies of Thorner, Lindemann, Harris, Herman, and others who have found that the amytal acts to produce an easy path for the translation of emotional reactions and patterns into speech and action. These studies are paralleled by the Rorschach findings and in cases, who either because they are unable to respond to the cards because of an inherent psychopathological situation or because they deliberately prefer to be uncommunicative, intravenous sodium amytal medication prenarcotic doses will prove to be a useful adjunct.

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POSITIVE AND NEGATIVE RORSCHACH ORGANIC REACTIONS

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When, in a field of science, we can not know everything with certainty, it is more advantageous to have certain knowledge of something than to have probable knowledge of everything. Certain knowledge can be applied in a manner assuring definite and predictable results; the application of probable knowledge leads to vague and much less predictable results. Thus in sciences interested in the practical application of their findings the search for certain knowledge is encouraged even if frequently this knowledge must be limited to a small but clearly defined group. A number of tests in the medical sciences are a result of the preference for certain knowledge even though not applicable to all; e.g., nearly all who give a positive reaction to the Wassermann test have syphilis but many who have syphilis do not give a positive Wassermann reaction; the positive reaction is significant, the negative reaction is not significant. These tests permit us to make a definite statement only about those who satisfy the positive criteria of the tests; nothing definite can be said of those who do not satisfy the test criteria. The Rorschach 'organic signs' are a test of the same type: when a patient's Rorschach record contains five or more of the signs, a marked personality change caused by an organic cerebral disorder may be reliably inferred (3); however when there are less than five signs, there may or may not have been a personality change of organic cerebral etiology; nothing more definite can be concluded from the mere fact that the Rorschach record contains less than five organic signs (5). Some organic disturbances of the brain do not alter the patient's personality in a degree to make the personality change discoverable by means of the ten organic signs or other Rorschach components.

A. The percentage of organic patients with positive Rorschach organic signs, i.e., with five or more of the ten organic signs in their Rorschach records, depends on the degree in which the patients' personalities deviated from the norm and on the age of the patients. The Rorschach records of 84 organic patients (20 below and 64 over 18 years of age) were obtained in the New York State Psychiatric Institute, in the Psychiatric Department of Vanderbilt Clinic and in the Montefiore Hospital. The latter, being a hospital for chronic diseases, treats patients who as a group have deviated much more markedly from the norm of healthy adults than patients attending the two other institutions. The Montefiore organic cerebral cases showed a much greater incidence of positive Rorschach organic reaction than the other patients.

Average personality deviation determined clinically	Number of patients Age over 18 yrs.	Patients with 5 or more Rorschach organic signs: absolute number	Patients with 5 or more Rorschach organic signs: % of total	Source or Institution
	34	30	88%	Montefiore
Very marked	6	5	83%	Schenk (6)
	40	35	87%	Total
	30	16	53%	Columbia Med. Center
Less marked	12	4	33%	Schenk (6)
	42	20	48%	Total

* Columbia University, N.Y. State Psychiatric Institute and Hospital.

All of these 82 patients were adults, over eighteen years of age. Age has an effect upon the incidence of the Rorschach organic signs, independently of the seriousness of the cerebral disease process. Statistical figures do not reflect the influence of age adequately unless the patients are subclassified according to the degree of personality deviation. For, older people with marked and organically determined personality changes nearly always have positive Rorschach organic reactions, while the majority of pre-puberty cases with marked and organically determined personality changes have negative Rorschach organic reactions, i.e., records with less than five of the ten organic signs.

Period	Age in years	Number of patients (including Schenk's)	Patients with 5 or more Rorschach organic signs	
			absolute number	% of total
Pre-puberty	below 12	12	5	42%
Puberty	12 to 17.9	8	4	50%
Post-puberty	18 to 50	64	39	61%
Post-puberty	over 50	18	16	89%
Total		102	64	63%

The effect of a major disease upon the personality of children is not quite the same as its effect upon the personality of adults. This does not apply only to the effect of demonstrable organic disorders in the brain but also to that of the schizophrenic disease process. The personality pattern of preadolescent children diagnosed as schizophrenics is not quite the same as that of adult schizophrenics (4). The degree of the patient's maturity partially determines the symptoms through which the effects of the disease process upon the patient's personality manifest themselves. Some of the Rorschach organic signs imply autocriticism or a reflective attitude which are rarely found in pre-puberty children. These signs are 'plx', i.e., perplexity associated with distrust of one's ability and quest for reassurance, and 'imp', i.e., impotence or giving a response in spite of recognition of its inadequacy. They do not occur frequently. According to Schenk, they point to organic defects of the cerebrum (7:21). The author apparently means that those two signs are specific of personality changes caused by an organic cerebral disorder and strongly suggest such personality changes even in the absence of other Rorschach organic signs. Certainly 'imp' and 'plx' do not occur in the records of healthy adults at all; they are pathognomonic signs. They do occur however in a certain percentage of neurotics with serious personality disturbances: 'imp' in about 8 per cent and 'plx' in about 2 per cent of these neurotics.

Source	Neurotics Total number of serious cases	Neurotics with sign: 'IMP'		'PLX'	
		absolute number	% of total	absolute number	% of total
Schenk (6)	27	2	6.9%	0	0.0%
Piotrowski	24	2	8.3%	1	4.2%
Total	51	4	7.8%	1	2.0%

Some Rorschach organic signs can not be used as indicators of personality disorder in children below the age of twelve because they point to immaturity rather than abnormality. They are significant in adults as indicators of retardation or regression of personality development. Examples of such signs are 'M' and 'F%'. The majority of children below twelve, including a large proportion of those without any personality problems of a psychopathological nature give no human movement interpretations. Thus 'M', i.e., giving of no more than one human movement interpretation, can not be a pathognomonic sign in childhood. Well adjusted adults however, especially those of superior intelligence, give at least two human movement interpretations; this differentiates them markedly from the maladjusted adults: the signs 'M' appears in about three-fourths of psychoneurotics (2), in about ninety percent of organic patients; 'M' occurs in nearly all records of organic patients with marked personality deviations. Similarly, the forms projected in the inkblots are less acutely perceived in childhood than in adulthood. Thus it is necessary to score the acuity of projected forms more leniently in childhood than in adulthood. The sign 'F%', i.e., a percentage of sharply perceived forms of less than seventy, does not have quite the same psychological implication in the case of children and adults.

The Rorschach method reflects the psychological condition of the patient. Any noticeable change in this condition affects the Rorschach record. Successful operations improve the organic patient's psychological condition by removing some of the causes of his mental disorder. Consequently the postoperative records of successfully operated patients should be better than their preoperative ones; available evidence indicates that they are better (1). We find therefore in the postoperative Rorschach records of organic patients somewhat fewer organic signs than in the preoperative records of these patients.

B. It is desirable that the greatest possible proportion of organic cerebral patients give the positive Rorschach organic reaction. However it is more important to establish the percentage of cases who are not suffering from an organic cerebral disease process which involves the brain although their Rorschach records contain five or more of the 'organic signs'.

All of the 9 cases with a positive Rorschach organic reaction, published by Schenk (6), were actually organic. Fifty-five of my 56 cases with this reaction were diagnosed as patients with organic cerebral disorders, one was diagnosed as a case of anxiety hysteria. Dr. Harrower Erickson drew my attention to a record obtained from a schizophrenic woman; this record contained five of the ten signs; qualitatively however it had a decidedly schizophrenic stigma; 1 response was given to each blot; six were sexual with a personal reference ("my insides"); one was an abstract interpretation (II: "heaven or earth"); the patient spoke of religion and discussed the attitude of the different churches toward sex life; there was one human movement response, blot III; the patient made it clear that she had strong guilt feelings because of her sexual life. This case teaches us that if a record contains a large proportion of sex answers given in a compulsive like fashion and if the patient is more disturbed by the content of his responses than by their adequacy (the degree in which they fit the respective inkblots), we must be careful in making diagnostic suggestions based on the presence of five or more signs. It is necessary to emphasize the warning that only a careful personality description can be the basis of a satisfactory diagnostic classification (3:535). A qualitative analysis must complete the computation of signs.

The anxiety hysteria female patient gave only anatomical responses. She was very fearful and was not capable of prolonged and rational reasoning. It is possible that had the Rorschach examination been repeated with the instruction to give other than anatomical content, in accordance with Dr. Ross' procedure (8), the patient might have given a second record with a negative Rorschach organic reaction. It is imperative to keep in mind that the degree in which one's personality is projected into the inkblots varies from individual to individual, and that it may vary in the same individual from time to time. When the subject leaves a weak imprint of his personality, the Rorschach personality analysis is more difficult than when the imprint is strong. The strength of the imprint affects the difficulty of the Rorschach personality description rather than its validity. Since the 'organic signs' are a very simplified and incomplete procedure of analysing Rorschach records, some of the personality traits, manifested in the Rorschach in a more subtle manner, escape the test of signs. Anxiety may be so strong in a person that in his Rorschach record it may overshadow all other traits so that the discovery of these traits may require a minute and thorough analysis. In such cases the criterion of the signs must be applied with great circumspection. We can presume that all individuals who give a 100% anatomical record are anxious. In completely anatomical records the number of signs is spuriously increased: for we will find in them always 'Rpt', 'M', 'F%', and frequently also 'R' and 'Imp'.

Dr. Ross' discovery that records with complete anatomical perseveration may be rather frequent is of considerable significance (8). Table I in his article indicates the frequencies with which such records occurred in the various groups examined by Dr. Ross. The incidence of complete anatomical perseveration was about the same in all groups and it was approximately 8 per cent. The incidence is by far smaller in my material comprising records from over 800 different individuals. It is not essential to know the exact percentage of records with anatomical perseveration; it is useful to know that in some samples of the total population one may find as many as 8 per cent of such records, in which the number of 'organic signs' is spuriously increased. Dr. Ross proposed a procedure by means of which we can determine whether the number of signs in the anatomical records is, or is not, deceptive. The simple but excellent device consists in asking the subject to interpret the inkblots again but to withhold from giving anatomical responses. In his Table II we find that in 17 out of 18 records with purely anatomical content there was a positive Rorschach organic reaction. When the patients were requested to abstain from anatomical answers and the examination was repeated, the Rorschach organic reaction remained positive only in patients with clinical evidence of central nervous system lesions (regardless of whether the lesions were permanent or temporary); in all non-organic patients the reaction became negative, the number of signs dropping below five. It is therefore necessary to follow Dr. Ross' procedure and to use the second record for diagnostic purposes if a patient gives only anatomical responses.

It is easy to produce numerous records of normals, psychoneurotics and psychotics with negative Rorschach organic reactions. The best control group for the cerebral group would seem to be one composed of patients who had been seriously considered to have cerebral lesions and in whom the possibility of cerebral lesions was excluded after a longer period of observation. One of the 25 patients in such a control group gave a positive Rorschach organic reaction: the anxiety hysteria case with complete anatomical perseveration. None of the 27 neurotics whom Schenk included in his control group had more than four signs. Cases in which the medical staff did not reach a definite diagnosis have been omitted.

It is advisable to adhere closely to the definitions of the signs (3:527-529) when scoring a record. When in doubt, it is better to leave out a sign and not to score it. It is indicated to qualify the definition of the sign 'P%' by stating that the percentage of popular responses should not be computed if the total number of responses exceeds 25; in long records 'P%' ceases to be a pathognomonic sign because of the limited number of popular responses.

In conclusion, the positive Rorschach organic reaction, i.e., 5 or more of the 10 'organic signs', is a very reliable aid in recognizing personality changes caused by organic cerebral disorders if adequate precautions are taken in obtaining a satisfactory record and in adhering closely to the definitions of the signs when scoring the records.

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INTRODUCTORY REMARKS TO THE PANEL DISCUSSION ON PERSONALITY STUDIES IN THE CONVULSIVE STATES.

S. Eugene Barrera, M.D.*

Scientific method in general deals with the study of relationships of various types between systems of various types and degrees of complexity in terms of certain assumed planes of reference. In some of the sciences the systems, such as points, and the relationship between them are relatively simple and subject to a large degree of control. In the clinical medical disciplines, e.g., psychiatry or neurology the psychiatrist also attempts to study relationships of a similar type. Generally, however, he is faced with a greater degree of complexity and difficulty, especially if he attempts to go further than hit or miss therapeutic procedures. In his work he is usually presented at first with one system, a certain effect or clinical syndrome, which itself might be exceedingly complex and difficult to delimit satisfactorily for study. Then, in relation to his work there are usually numerous other systems which in turn again are usually very complex, any one or some of which may have some important relationship to the initial effect observed. The medical scientist is interested in studying these systems and relationships so as possibly ultimately to control and change them.

Such, in general terms, is the situation concerning the problem of "personality" in so-called "epilepsy". The medical scientist begins with the last. The clinical syndrome called "epilepsy". This term, of course, conveys to a clinician familiar with his field not only the idea of the general fit or convulsion but the idea of a whole series of graduations of convulsive disturbances, even without motor manifestations at all in some cases. Much might and has been written concerning the limitations of the term epilepsy. It is certainly not characterized sufficiently by the general fit any more than hyperthyroidism is represented by a rapid pulse or pneumonia by a high fever. The convulsive seizure is one more or less externally manifested occurrence in a "convulsive disorder".

Disregarding for a moment the great complexity involved in careful definition of our one system, the clinical syndrome or effect, epilepsy, we may safely say that some cases are clear cut out and out convulsive disorders. Such disorders should be amenable to scientific delimitation and even controlled experiment. The disorder presents a change in behavior which is usually observable and describable by photographs, simple observations or measurements of various types. It usually runs a cycle in time permitting a satisfactory period of observation. It is repetitive, allowing repeated observations in its course. It is associated with many changes within and outside the individual which may be observed and occasionally controlled to some extent. Finally, the disorder, in at least its convulsive portion, can be reproduced experimentally both in animals and in man. So much for the "epilepsy" pole of the problem.

At the other pole of our question here today we have so-called "personality". Our problem is to relate these two poles in some way after having sufficiently delimited the poles themselves. Some neurologists and psychiatrists, e.g., Dr. L. Pierce Clarke, felt and claimed, after long study of cases with chronic so-called "idiopathic epilepsy" that a more or less well defined "personality reaction type" was present in many cases. These personality

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studies were usually long and laborious, utilizing very often psychoanalytic methods and concepts. The existence, however, even of such well-defined personality types has been denied by other psychiatrists. Likewise, studies made by the use of the Rorschach method on selected cases of convulsive disorders have revealed, in the hands of some investigators, a sufficiently delimitable pattern of responses to again justify our belief in the concept of an "epileptoid" personality type of response. Assuming for a moment that such definition of the personality is possible, for our own purposes here today, we are then faced with the problem of ascertaining the matter of relationships between our personality on the one hand and our convulsive disorder on the other. Superficially it would seem that at least three types of relationships must be considered: (1) That the "personality" found is really a result of the convulsive disorder. This would seem to be indicated by some studies in which it was claimed that the major manifestations of the clinical personality type only seemed to develop after convulsions had occurred for some time and were more prone to be present in cases developing seizures early in childhood. (2) That the "personality" and the convulsive disorder might be simply incidental to each other, or both related in some way to some human factor genetic or not, but not directly related to each other. (3) That the convulsive manifestations are merely a necessary outgrowth of the "personality", a form of the adaptation of the personality to the environment. This sort of relationship was that claimed by Clarke and has been suggested by other psychoanalysts.

At any rate, the problem of the so-called "epileptic personality" is far from being solved. Since the Rorschach test, to my mind constitutes probably the most rapid, most important single clinical method of personality reaction type patternization, I feel it would be very interesting to hear a few of the experiences of some who have had experience in its application to cases of convulsive disorder.

A STUDY OF SOME PERSONALITY DIFFERENCES BETWEEN EPILEPTICS AND NORMALS

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Within the limits of the present study,* it is not our intention to argue the point as to whether there is a so-called "epileptic personality" that predisposes an individual toward the disease. Rather are we more interested in studying the behavior and attitudinal differences that may be found between epileptics and normals. More specifically, we wish to determine whether there are modes of behavior and specific attitudes typical of epileptic individuals. If so, whether these modes of behavior and specific attitudes represent in large part the response of such persons to the problems and situations which the very nature of their disease creates.

Of all the work done in the field of epilepsy, few investigators, if any, have seen the need for the control of epilepsy as a physical disease. That is, they have been content to contrast epileptics with normals, assuming that the differences obtained were due to epilepsy. But it is our contention that the obtained differences may not be due to epilepsy but to any organic disturbance. It is necessary, therefore, to equate for organic disease by introducing a control group that is equated with the epileptic group. In addition to this control for the physical disease itself, we are also interested in testing some of the assumptions implicit in the work of Gibbs (1), Strauss (2) and others on the electro-encephalograms of epileptics. Not only have they found evidences of abnormal brain waves in epileptics, but also in the siblings and relatives of the epileptics. The question then arises as to the possibility of the siblings, who show no overt clinical signs of epilepsy, possessing a latent epileptic personality which may predispose them to convulsive seizures at some future time.

Our experimental set-up consists of four groups of subjects:

1. Epileptic group - twenty idiopathic subjects with an age range from 10 years to 21 years. Non-institutional patients.
2. Sibling group - consisting of siblings of epileptic group, equated with epileptic group for age, sex, education, etc.
3. Cardiac control group - to equate for the physical disease itself, we are using a cardiac group.
4. Normal group - consisting of the siblings of the cardiac group and equated with the above three groups.

Besides the use of standard intelligence tests (with an item-analysis of the revised Stanford-Binet test), the level of aspiration technique, the Self-Ordinary-Ideal Rating Scale of Lennig Sweet and as modified by Rubenstein (3), we have utilized the Rorschach Ink Blot test as one of our main psychological techniques. The following is a tentative analysis of some of the Rorschach results for the epileptic and sibling groups.

* The present study is a phase of a larger investigation now being conducted at the Neurological Clinic of Mt. Sinai Hospital. Complete neurological and psychiatric studies are being made on the epileptic group. Encephalographic work is being done on the epileptics and possibly on the siblings of the epileptics.

ANALYSIS OF RORSCHACH RESULTS

I. Mental Approach

a) "D" - Both groups have normal consideration for obvious details. However, the consideration is more even in the sibling group.

b) "W" - Both have the same emphasis on the tendency to use the whole ink blot. The overemphasis of W's is more extreme among the epileptics than among the siblings. This difference is further enhanced by the distribution curve:

	20% - 40% W's
Epileptics	20% of group
Siblings	48% of group

Not only do epileptics have a higher emphasis but also a more extreme attitude. The high frequency of W's for the siblings is close to the average area of W's with a slight emphasis. It is quite near to what is expected in normals. The epileptic group has only 20% of its subjects within the normal or average area. The remaining subjects are scattered in the two extremes.

The quantitative differences are made more striking when we consider the quality of the "W" responses. The W's of the siblings are better. The drive of the epileptics to give "W's" carries them not only to give extremes in quantity but also in quality. Their disregard for form accuracy and the given data is greater. Dr. Klopfer interprets the "W" trend among epileptics as a compulsive form of mental aggressiveness. We also find that 40% of the epileptic group are afraid of this tendency and avoid "W" responses as far as possible. They are overcareful in their approach and give less "W's" than what is expected. This tendency is not as marked, though present, in the sibling group.

c) Time: Whereas 100% of the sibling group need less than one minute per response, 73% of the epileptic group require more than one minute per response.

II. Degree and Mode of Control

a) Form %: There is a tendency for epileptics to concentrate at upper extremes. (Epileptics -- 49%; Siblings --34%).

b) F%:(FK% + Fc%) (the closer F% is to the sum of FK% + Fc%, the better the modification).

Epileptic Group - 7:1
Sibling Group - 2.5:1

Hence we find that epileptics show cruder constriction.

III. Emotional Adjustment

The ability to combine the emotional with the rational within an emotional situation is expressed in the ability to combine definite form with definite color. Whereas when color alone is definite and form indefinite or not considered at all, we have an indication that one is inclined to be overwhelmed by an emotional stimulus without having the ability to react rationally to it. This may be briefly expressed in the relationship of FC: (CF+ C).

	Total No. of FC's	Total No. of CF + C
Epileptic Group	13 + 5	19 + 6
Sibling Group	31 + 10	22 + 6

This reversal of FC and CF indicating maladjustment among epileptics and adjustment among siblings is true in spite of the fact that the epileptic group used color only half as often as the siblings. It would seem that the attempt on the part of the epileptic to avoid color was unsuccessful.

When we consider the relationship between adjustment (as determined by the FC: (CF + C) ratio on the Rorschach) and duration (length of time in which individual has been subjected to attacks), a striking trend is revealed. Those subjects who show the longest duration tend to be maladjusted while the epileptics who have the shortest duration of the attacks tend to be better adjusted. This finding corroborates the clinical assumption that patients who have had idiopathic epilepsy for a longer period of time tend to be more maladjusted.

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RORSCHACH CASE STUDIES IN THE CONVULSIVE STATES

Douglas M. Kelley, M.D.* and Helen Margulies, M.A.

In this communication we are presenting two complete Rorschach records selected from among the records of a group of patients who were observed at the N. Y. State Psychiatric Institute and Hospital. These particular records have been chosen as exemplary cases because though they differ from one another to a considerable degree, they are yet fundamentally alike in their portrayal of a personality picture which has been described as characterizing the so-called epileptic personality.

The Rorschach records were not obtained by the authors and were analyzed independently and with no other knowledge of the patients' personality or clinical condition than that they were subject to frequent grand mal seizures.

In addition to the Rorschach records the cases were carefully studied from a clinical psychiatric point of view and with other psychological methods. This material was subsequently analyzed and is included in part to aid in checking the Rorschach findings. In general the findings are in complete agreement and thus these two reports serve to indicate the clinical use of the Rorschach method in studies of this type.

The procedure of interpretation of the Rorschach responses had been detailed at unusual length in order that the actual basis for each assumption could be easily seen and that the methods of differential diagnosis could be clearly depicted.

As a means of describing the location of the responses we are using the numbers and descriptions given to the usual details (D and d) in the article "The technique of Rorschach scoring and tabulation" (5).

Case I - Male. C. A. 20 yrs. 10 mos.

	Performance		Inquiry
		Card I	
1"	1. Looks like a bat.		1. Looks like it's flying...wing spread out...funny looking bat. Head up to the sky..doesn't seem to be flying. (Same concept; bat and moth). (Whole)
20"	Bat or any other kind of moth or butterfly.		
35"	2. Might be a canyon over there.		2. (Cross section, V shape at upper, inner, claw-like extensions 3).
50"	That's about all I can make out of it. Can I		
	> turn them around?		
1'20"	That's about enough. Might say they are similar on both sides. (returns 1'25" card).		

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Case I Continued

Performance			Inquiry
		Card II	
40"> V ^	1.	This looks like..kind of tomahawk. Kind of stone hatchet, this part over here.	1. (Upper portion only of upper center d l). Additional a) (Lower red I) An ink spot I guess, a blot. b) Might be poles on a barber shop, with stripes..a little thin. Red and white. (projections on lower red).
1'25"		That's about all.	
1'40"		It's similar to this one. (Picks up card I).	
		Card III	
20"	1.	Can make a butterfly out of that.	1. (Inner red I) It's alive and flying, minus the head.
50"	2.	Oh it looks like a.. (snaps fingers)..What the Hell's the matter with me; can't think of the name. A bee; some kind of creature like that..cockroach.	2. Rear end is missing..outside, not the inside. Might be cockroach because it seems to be climbing up a wall, or crawling along the ground. When you see something crawling on the ground it might be a cockroach. First struck me as parked on a wall, crawling upwards. (All except red).
1'10"		That's about all. (Returns card).	
		Card IV	
15" ^ V ^		Of course they're all similar on each side; don't have to tell you that.	
40"	1.	Looks like the head of another bee, cockroach or another moth. This might be wings, this might be the body.	1. This might be legs..also seems to be on tree or on a wall. Might be legs, but not necessary. (Whole) Additional Might be head of a dog; eyes, ears, snout. (Lower center I)
1'20" V		Guess that's about all of that. (Returns card).	
		Card V	
5" ^ V	1.	All seem to resemble bee or moth, with antennae, legs out in back here.	1. This one is flying definitely. More like a moth..long antennae. Butterfly too, of course. (Whole).
55" ^ V ^		That's all.	

Case I Continued

		Performance	Inquiry
		Card VI	
15"	1.	Can make out another moth or bee out of that. (Blocking off using top only).	1. (Entire upper portion II) Would be too fat to the edge. Use the inside dark part. But on the wall or tree (no movement).
35"	2.	Sort of like a river here. (Points) Palisades, Hudson; about as straight.	2. River is running. Little white line is the river. Palisades on the sides. Seems to be coming in that way (Demonstrates a V shape with his hands).
55"		Like Lake Mohawk; ever seen it on the map?	Running out of the lake. Might be another lake down at this end.
1'15"	3.	This might be the Grand Canyon down in there.	3. Cross section, not looking far into it. (v shape at bottom of card). Additional And these little marks; if the other way around might be a bull; horns. (Bottom outer projections 4)
1'30"		That's about all. (Tells of having taken this test before; over at Neurological Institute.)	
		Card VII	
7"	1.	First thing that hits my eye is the blank white space.	1. The middle section seems to be blank white. Might be top of tomahawk. My mind isn't working; that isn't what I mean. (Turns it over). Additional a) Like the wig of an 18th Century gentleman. b) And a Xmas tree if a little more pointed..if kept going.
45"	2.	Can make out a profile of Washington you know, the new monument. (Describes carefully. Not the usual face but just lower portion).	2. (Draws in face; tilts it one way to get side perspective). Terrific imagination. (Lower part of middle third II).
1'30"		That's about all.	
		Card VIII	
2"		Very pretty coloring.	
10"	1.	Oh can make out a wolf..both sides, that is.	1. Seem to be on the prowl. Looking for something to eat. (Side pink I).

(Continued on next page)

Case I Continued

Performance			Inquiry
		Card VIII Continued	
30" V	2.	Might be head of a ram..horns stick out..no eyes..have to use imagination. Horns sticking out at side.	2. Or it might be head of bull. (Lateral extensions of bottom orange 1).
1'20" ∧	3.	This might be dogs front feet, not the rest of the body.	3. (Locates the legs - lower).
	4.	Another legs of body. This one in motion, this one still.	4. Projections on top grey portion III). This one might be a grey hound running. You can see his legs out in back. This one standing, might be waiting for a bone or some food. Same on each side.
1'55"		That's all for number VIII.	
		Card IX	
15">V		I pictured many more last time. (Patient had a Rorschach several months before).	
25" <	1.	Oh this might be head of a camel here. Both sides of course. (Studies intently, and turns much).	1. (Small inner portion at conjunction of green and orange III).
>			
1'30" V	2.	Lot of things that might be something, but not good enough.. imagination. Hind legs of dog..body.. out of shape. Use imagination and can picture it.	2. He's running all right - back legs stretched out. Not a good picture. (portion of upper inner orange projections 1).
2'30" < 2'45"	3.	Head of a bison; eye.. I guess that's about enough.	3. Looks like head of a St. Bernard; instead of horn might be his ear. (Inner pink portion VIII). Additional Head of a ram if had horns. (Lateral pink IV)

Case I Continued

Performance		Inquiry
	Card X	
10"	Coloring is very odd; very pretty.	
30" V∧ 1.	Might be two watermelons.	1. Two cantaloupes. (Usual pink portion IX).
45" 2.	Might be head of ram.. or a moth..	2. (Inner orange XII).
1'25" ∧ 3.	This might be telephone pole right there.	3. Straight and thick. (Gray column at top without gray "animals" beside it. XIV).
1'55" < 4.	Might be sleeping St. Bernard, squatting, very furry thing.	4. Very fuzzy and hairy. (Outer orange XI).
2'15" ∧ 5.	Might be head of a mule; two big ears, eyes, nose. (Sighs).	5. (Usual rabbit's head VII). a) Could be figure of a woman dancing..like a flying swan dance.. on a poster. Might be like on a radiator cap, Chevrolet. (Inner yellow X) Maybe shouldn't have said that; probably land on 8th floor. Do you think I'm sane? (8th floor is disturbed ward).

Limits

Can see bowing men in Card III. "But that using the imagination too much". Likes card II best, "Because of deep coloring." Likes card VII least.. no reason.

Case I

Scoring

I. 1. W F A P
2. d F N

II. 1. dr F obj.
D CF blood
dd FC obj.

III. 1. D FM A P
2. W FM A

IV. 1. W F- A
D F Ad

V. 1. W FM A P

VI. 1. D F A
2. D FK,m N
3. de F Geo
d F Ad

Case I - Scoring Continued

VII. 1. S F obj.
2. dr F HD
S F obj.
S F Pl

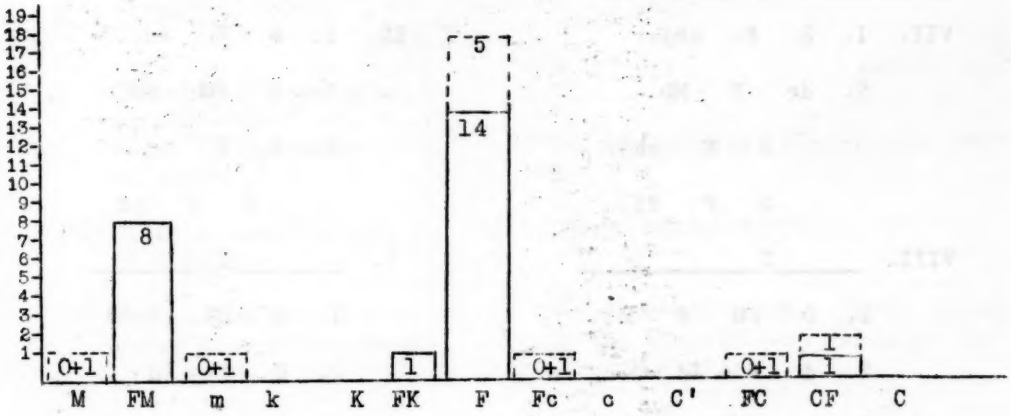
VIII. C
1. D FM A P
2. d F Ad
3. dr FM A
4. dr FM A

IX. 1. D F Ad
2. d FM Ad
3. D F Ad
D F Ad

X. C
1. D CF food
2. D F Ad
3. D F obj.
4. D FM,Fc A
5. D F Ad
D M(F) H

W	4	M	0 + 1	H	0 + 1
D	11 + 3	FM	8	Hd	1
d	3	m	0 + 1	A	1 0
Dd	5 + 1	k		Ad	6 + 3
S	1	K		obj.	3 + 2
		FK		N	2
	24	F	14 + 5	Geo	1
		Fc	0 + 1	blood	0 + 1
		c		Pl	0 + 1
		C'		food	1
		FC	0 + 1		
		CF	1 + 1		24

24



16.7% 45.8% 12.5% 20.8% 4.1%
(W) D d dd & s

Responses 24

Total time 16' 40"

Average Time per Response 42"

Average time up to first response to non colored cards 13.6"
Average time up to first response to colored cards 25"

F = 58% with 1 F-.

A + Ad = 67%

P = 4 = 17%

O none

(H+A):(Hd+Ad) = 10: 7

M: Sum C = 0: 1

(FM+m) : (Fc+c+C') = 8: 0

$\frac{\text{Cards VIII, IX and X}}{\text{R.}}$ = 50%

W: M = 4: 0

Succession: Fairly orderly approach

Case I Discussion of the Rorschach Record

Quantitative Analysis

A. Choice of Location for interpretation

(W) D d Dd + S

1. Under-emphasis of wholes.

2. Strong emphasis on rare detail and use of space. Rare details used are dr and one de. They occur as parts of commonly chosen d's and D's. In Card II the upper portion only of the most frequently chosen d is used; in VII part of the usual mask; in Card VIII a dr which is not too uncommon. The S is one of the most obvious (Card VII).

3. Presence of normal amount of D and d.

4. Succession - fairly orderly approach.

Interpretation and preliminary Hypotheses

a. Possibility of schizophrenic mental approach because of emphasis on rare details which means sensitivity to minor elements in material before subject. Beck (1) found that a Dr approach was a reliably differentiating sign of schizophrenia. Kelley and Klopfer (4) report this finding.

b. But schizophrenics give confused succession more often.

c. It will be necessary to examine the quality of W's and to note whether or not DW's and other signs of schizophrenia occur.

d. The rare details are not bizarre or unclear which Kelley and Klopfer (4) found to be qualitatively important in schizophrenia.

B. Distribution of Determinants

1. No main and one additional M in an unusual place (X).

This indicates that the subject is not expending any energy in inner mental activities of a creative, imaginative kind. The presence of M indicates the role of the imagination which is intimately connected with "the individual's conception of life according to which he makes his adjustment to reality" (Piotrowski 9). It represents the individual's ideas, goals, strivings, philosophy of life, observations and analysis of his subjective experiences.

2. Large number of FM's in comparison to rest of determinants

If the number of FM's is greater than the number of M's (with fewer than 5 M's) it indicates that the subject is emotionally infantile. "FM's represent the influence of the more instinctive

layers within the personality: the attitude to instinctive drives." (Klopfer 6).

3. High F% (58) with one F- response

This indicates rigidity or constriction, implying lack of spontaneity. Since there is a marked decrease in spontaneous expression and creative thinking one must infer inner tension. "The presence of F- in a rigid control system damages effectiveness of control much more than a few F-'s in a generally very loose control" (Klopfer 6).

4. CF and FC

The presence of only one CF plus one additional CF, and one additional FC (Note that under pressure in Card II the subject gives a CF and then an FC) indicates that the patient has not much spontaneous emotional contact with the environment. If pressed he would explode impulsively. A more adjusted reaction would only come as an afterthought.

Hypothesis

a. FM is greater than M, no main M, F% is above 50, CF is greater than FC. Hence we must look for other signs e.g. color shock which might show a neurotic personality structure. Since FM is greater than M and CF greater than FC a mixture of infantilism and lack of control is given. However the record does not show the anxiety and unsuccessful inhibition (K,m etc.) of the neurotic picture.

C. Relationship between factors

1. Number of responses equals 24 which is within the average range.

2. Time per response is 42" which is slow but within the normal range.

3. There is a marked difference between the average time up to the first response to the colored cards (25") as compared to the non colored cards (13.6"), almost twice as long.

4. It has already been pointed out that 58% in the F column indicates constriction or rigid control. The percent in the control area is even greater when we take into consideration the FK response.

5. A% is 66% which is high. Therefore this patient has a paucity of ideas. A glance at the content shows a very narrow range of interests which indicates stereotyped mental activity.

6. Low P% (17%) is found in schizophrenics, organic cases and neurotics.

7. There are no main original ideas. This factor is used in the estimate of intellectual level. Since there are no main M's (and only one additional) and few W's, we would have to look at the quality of the W's and the quality of F's in order to estimate the level of intelligence.

8. (H+A): (Hd+Ad) - 10: 7. This indicates the likelihood of this patient being over critical, over concerned, with unimportant matters. Also this fact together with the low P% indicates that the subject does not have sufficient good judgment along the lines which are considered obvious by other people. However the presence of D helps him from being entirely impractical. The optimum relationship between these three factors in order to warrant an interpretation of common sense would be a normal amount of D's, a ratio of twice or more than twice as many whole human and animal figures as parts and a higher P%.

9. M:sum C is 0:1; (FM+m): (Fc+c+C') is 8: 0; $\frac{\text{Cards VIII, IX, X}}{\text{R}}$ = 50%.

This shows that the patient at present shows a strong desire for contact with the environment (more bright color than movement and 50% of the responses to the last three cards which are colored). This, together with the high number of FM+m, indicates that the subject is making a tremendous effort to balance this extroversial swing, but at present is unable to control his reactions toward this environment and will be carried away in most instances by his impulsive reactions to external stimulation.

D. Observations from record

1. Attitude to test

There are indications that the patient is very serious about the test. It seems to be important to him to make a good showing and to impress the examiner, which he tries to do. (Card I he makes an attempt to give a number of responses and takes 50" to tell us that the first responses are enough ("That's about enough") and that he can't make anything more of it. Then he adds an obvious remark "might say they're similar on both sides", adopting as his own that which has already been pointed out to him in the instructions and which he is sure is right. It seems to act as a sort of escape from the unpleasant situation of not being able to give any more interpretations. In order to impress the examiner with his knowledge he asks (Card VI) "Ever seen it on the map?". He brings in the irrelevant idea of the Washington monument (Card VII). When he is unsure of himself he attempts either to cover it up by implying he is not himself e.g. card III "What the Hell's matter with me, can't seem to remember"; blames the cards e.g. card IX "Lots of things might be something, but not good enough"; or expresses doubt as to the advisability of having given an answer e.g. card X additional response in which he gives his best answer and then says, "Maybe shouldn't have said that; probably land on 8th floor" (disturbed ward).

2. Way of handling situation

Here we find the presence of a pathological sign - repetition of an idea. The same response was given to several inkblots. The patient felt compelled to give some response to the inkblots, even when his imagination failed him. Since he has a paucity of ideas and therefore no appropriate responses, he repeats an old response rather than be silent (Piotrowski 10). Card III was a cockroach. In Card IV he utilizes his previous concepts used in Card I "moth" and

card III "bee or cockroach". In Card VI he says "Can make another moth or bee out of that". In the inquiry he repeats the concept of animal "on the wall or tree". (Card III, IV, VI). He also uses the concept "canyons" repeatedly.

3. Qualitative and Sequence Analysis

Form Level

To Card IV the patient gives an inadequate form response which in content is a repetition of previous answers (Card I and III). In Card X the stimulation of the color is so strong that the patient gives a response which completely disregards the form ("watermelons", "cantaloupes.") The quality of the form responses in general is somewhat stable on an average level without any really superior aspects about them. There are few or no elaborations and the concepts are narrow in terms of content. These qualitative aspects of the form level suggest a picture of a partial mental deterioration (Klopfer 6).

4. Movement

The patient gives no main M response. He gives an M only as an additional and that in card X. It is his only response which has a certain originality about it. But this response is immediately negated to a poster or a radiator cap. He goes even further. After he has given the movement response in the most innocuous place he can, and has negated it, he adds as his last comment, "Maybe I shouldn't have said that; probably land on the 8th. floor. Do you think I'm sane?" In the testing of limits he can see the bowing men in card III "But that is using the imagination too much."

This indicates that this patient is afraid of his own ideas. "The patient's unnatural behavior when he gave his best interpretation, his disparaging implications with respect to it implies that the patient doubts his own capacities, and is unwilling to commit himself to anything except the obvious, all of which is an indication of the restraint of inner life" (Piotrowski 11).

5. General sequence analysis

Card I. Inquiry. The patient projects his own inadequacy onto the card "funny looking bat". He approaches the situation with conscious control (use of form only as determinants for responses).

Card II. He avoids the use of color and chooses for interpretation a rare part. He takes the liberty of saying Card II is "similar to this one" (Card I). He disregards the real differences between Card I and II and goes to any length even to the point of absurdity in an effort to cope with the situation. This indicates that in difficult situations he is likely to give inappropriate reactions. In the inquiry he shows that under pressure his first reaction to color or emotional stimulation is likely to be impulsive (CF). His additional response indicates that he may have more controlled reactions as an afterthought.

Card III. The patient still avoids the use of color. However he is attracted to it since he uses a colored spot for interpretation. His verbal reaction to III seems to indicate a quickly roused irritability with himself in the face of a frustrating situation. He cannot give an adequate response and tries to cover up his feeling of inadequacy by attempting to make the examiner believe that he is not his usual self and for the moment things slip his mind. He is glad to rid himself of the card and relinquishes it without the usual delaying and inconsequential talking. In the inquiry he is illogical in the explanation of his concept of the 'cockroach'. Since he seems unable to explain his idea, he seizes on a way out, "When you see something crawling on the ground it might be a cockroach." The reaction is similar to that of a person who is likely to be dogmatic when confronted with a situation with which he has difficulty in coping.

His attempt at control in II (avoiding the whole emotional situation and withdrawing attention to the less prominent aspect of it, upper d) is to no avail in III where he gives a weak form response. This indicates that while in the face of emotional stimulation he attempts to use control, if the stimulation continues, his control is likely to fail him and he is apt to show an inadequate reaction.

Card IV. He shows his Paucity of ideas by repeating an earlier concept. As in III where he is disturbed under the stress of color (emotional stimulation), he gives a poor form response under the import of the shading. This indicates that his handling of situations involving sensitivity is inadequate.

Card V. He gives the usual response of moth or butterfly to it. But the presence of the statement "All seem to resemble bee or moth" implies a perseverating idea.

Card VI. The patient seizes on one idea (geography) and because of his paucity of ideas spends 55" in an effort to make the most possible use of it. His strong desire to do well is expressed in the effort to make a number of responses from one concept.

Card VII. There is a suggestion of a tendency to opposition in the use of white space. It is to be noted also that in his second answer in I "canyon" & VI "Grand Canyon" he makes use of the white area in a sense.

Card VIII. The subject is aware of the color yet he persistently avoids using it in his responses. Color here (emotional stimulation) induces in him an attempt at control or else infantile emotional impulses. The sequence is FM, F, FM, FM.

Card IX. The same sequence between attempt at control and giving way to infantile emotional impulses occurs here too. (F, FM, F).

Card X. Finally he can no longer restrain himself under the impact of continuing emotional stimulation (3 colored cards in a row) and gives way, reacting to the emotional stimulation from without with almost unrestrained impulsiveness (CF). Since there are 8 FM's, no M's and more CF's than FC's there is an indication of the presence of egocentricity and instability.

Summary of Color reaction

1. His attitude to the colored cards. He disregards the color in II, III, and IX and comments about the presence of color in VIII but does not use it. In X he also comments about the color but gives a CF indicating impulsivity.

2. Erlebnistypus. Since the number of answers to the last three cards are 50% and the ratio of M: Sum C greater on the color side he shows he is strongly susceptible to outside stimuli. The presence of such a large number of FM's in comparison to the other determinants indicates an attempt at control of his extroversial swing which however is not successful. He can be considered to be extroversial in basic personality configuration.

3. His first reaction to the presence of color is to avoid it. He avoids responding to emotional stimulation initially. When he does use a color spot, he does not combine the color as part of the response but just uses the location. Even when he is strongly stimulated by the color (VIII and IX) he avoids it, simply responding alternately with form and FM attempting to escape by control and by being aware of infantile impulses. If the stimulation becomes too strong (X), he responds impulsively without restraint.

4. There are some indications of color shock though the indications apply to cards which are heavily shaded as well. (e.g. Card II long reaction time; Card IV poor form).

Intellectual level

Qualitative aspects

1. The quality of the whole response shows that of four whole responses one is of poor form and the other three are average.

2. Comments have already been made on the form level indicating mental deterioration.

3. There are no human movement responses except one additional one.

4. There is only one additional response which has an element of originality to it.

5. The content is stereotyped.

6. Succession is fairly orderly.

We note the presence of several responses which can be considered above average:

Card II. 1. the Tomahawk.

VII. Additional. "Like the wig of an 18th. cent. gentleman."

2. Profile of Washington in which a rare detail was chosen.

VIII. 1. Greyhounds with one running and the other standing.

IX. 2. Hind legs of the dog running.

X. additional. The women dancing.

Since the responses which make use of other determinants are in general better than those in which only form are used, we can say that the intellectual functions show deterioration. The impression of an intellectual level which is above average but is in the process of deterioration is further substantiated in view of the fact that the presence of not more than one F- and the regular order preclude the possibility of a previous level of intelligence below normal, even though the usual signs which indicate intellectual level might lead one to suspect some degree of mental deficiency.

Summary of personality description

Emotional configuration

This record is that of a person who lacks spontaneous expression and creative thinking. He is constricted, afraid of his own ideas and doubts his own capacities so that he restrains his inner life. However the presence of poor form in a rigid control system indicates a damage to the effectiveness of the control. He gives a picture of infantilism. He shows he is strongly susceptible to outside stimulation. If stimulation becomes too strong, he no longer attempts control but responds in an impulsive, unrestrained manner. There are indications of egocentricity and opposition. He is sensitive but is unable to make good use of this sensitivity (F- in IV and VI).

Intellectual aspect

This subject may be considered to have an intellectual level above average. Indications are strong that there are signs showing mental deterioration. He has critical tendencies which on an average intellectual level would point to concern with unimportant details rather than keen scientific observations and critical faculties, and he has a paucity of ideas.

Differential diagnosis

The absence of the majority of schizophrenic signs especially the most highly differentiating ones (e.g. DW approach, confused succession, great variability between very keenly perceived form and absurdly poor form, high relationship between O- and high A% etc.; Kelley and Klopfer 4; Beck 1) leads us to eliminate the hypothesis that this is a schizophrenic picture. The occurrence of pathognomonic signs such as repetition of an idea are not those associated with records of neurotic patients. There is no evidence of the anxiety or repression found in neurotic patients. Also the signs which Miale and Harrower-Erickson (8) found to differentiate neurotics from normals and which occur here (e.g. "R, M, FM>M, F% more than 50, CF more than FC are common in schizophrenic (Kelley and Klopfer 4) and also in organic records (Piotrowski 10). Finally since we have no positive neurotic syndrome, we must eliminate the hypothesis that this is a neurotic personality picture. There is not an organic configuration and not enough organic signs to warrant the diagnosis of an organic brain disease.

We must consider one more possibility. Guirdham (2) lists certain signs of epileptic records which appear here:

1. Perseveration. "The type found in subjects of a more concrete intelligence as shown by the occurrence of a D-Dd Erfassungstypus and of a higher potential intelligence and includes a small sub-group where an unusually fine detail exceptionally well perceived as to form is sought for..."

2. Erlebnistypus "Extratensive or ambiequal". "Epileptics have far less development of introversive life than normals- marked by C greater than M".

3. Color "Presence of CF and C which indicate different degrees of unadapted affectivity."

4. W and detail answers. "Presence of many W's which are repetitious - perseveration".

5. Stereotypy.

6. P% lower than average.

He says that when constriction occurs it may occur with confabulation and perseveration. 62% of his epileptic subjects were constricted as compared with 45% in normals. What does not occur is the loose, reversed or irregular succession. He says low F+% (though the form is not particularly good) does not occur, nor are A + Ad % below normal. However there was no constant Rorschach reaction pattern.

The literature reports that many but not all epileptics display the following personality characteristics: unstableness, irritability, impulsiveness, sensitivity, egocentricity, susceptibility to flattery, boasting, childishness in direct proportion to the degree of insight and judgment in general, vanity, pedantry, and emotional poverty.

This is essentially the picture as presented by the Rorschach findings of the patient under consideration. Since the record is obviously abnormal and since differential diagnosis rules out other types of psychopathology, it seems reasonable to report an impression of convulsive states- not focal but probably ideopathic, as a result of this interpretation. It is impossible of course to give any information regarding the nature or number of seizures.

Clinical Discussion

Case I. In addition to having the previous Rorschach test the patient was also given a complete clinical workup including certain psychological tests. These tests included: the "Socially Competent Person", the "Specific Interest Inventory", the "Personality Inventory", the "Vocational Interest Blank" and the "Adjustment Inventory". It was felt that it would be of considerable interest to see if these five blanks together with other psychological studies yielded material in any way similar to that obtained independently by the Rorschach method. A revised Stanford-Binet form L showed a score of

18 yrs., 9 mos. and an I.Q. of 125. In contrast, his ability to handle concrete material, as evidenced by the Ferguson form boards, was so poor that his score fell below that of the lowest 10% of adult men. In general a test of this type showed a lack of adaptability when faced with unfamiliar situations.

These findings are borne out by the study of his judgment. The patient has very poor judgment upon matters regarding health, family, community relationships and civic problems. He does show fair judgment regarding personal economics, but is shown to have a rather poor general knowledge regarding the other subjects and his inability to make accurate judgments when faced with new situations. His range of interest is rather low. He is interested chiefly in outdoor activities, social activities, commercial activity, and some literary or studious pursuits. His range of interest is very limited. Out of the 48 activities listed in the Strong blank the only ones which he liked were: "Arguments, bargaining or swapping, looking in shop windows, expressing judgment publicly regardless of criticism, being pitted against one another as in a political or athletic race, continually changing activities and developing business systems." He is likewise only interested in certain types of people, out of the long list given, only finding favor with "Progressive people, energetic people, optimists, people who have made fortunes in business, emotional people, irreligious people, people who have done you favors, people who don't believe in evolution, socialists, bolshevists and athletic men." His occupation ranges, but for a few exceptions such as explorer or aviator, are entirely in the extraverted, outgoing type of work, such as general reporter, sales manager, secretary chamber of commerce, employment manager, advertiser, auctioneer, army officer, governor of a state, travelling salesman, etc. As regards amusement, he is also interested in extraverted types of play, particularly in the athletic field, and prefers extraverted activity and rates his abilities in an extraversial type of way. Throughout the entire study it is also to be seen that he is confident, likes to direct and control, seems definitely self-centered and filled with his own sense of ability.

These factors are brought out even further in the adjustment inventory and personality inventory which showed the patient to have few neurotic trends, although he does manifest considerable worry over his physical state. He occasionally feels blue, feels that his parents may be disappointed in him, envies the happiness of others and his feelings are easily hurt. He gets upset easily, worries too long over humiliating experiences but does not consider himself a nervous person. He is shown to be markedly egocentric inasmuch as all of the answers indicate that he is not troubled with shyness, prefers to work things out for himself, ignores the feelings of others when accomplishing some end important to himself, does not lack self-confidence and in general manifests an extraverted, querulous and argumentative type of pattern.

From these tests alone we are able to say that the individual is of high adult intelligence but curiously lacking in judgment and ability to face new situations. He is also lacking in judgment regarding personal relationships with the environment and manifests his reaction to the environment in an extraverted, egocentric, argumentative manner. He is self-centered, has a narrow range of interest, manifesting only those which are of specific value to himself in reaction to his environment and these when they suit his purpose, with disregard for the feelings of others. He is

fundamentally argumentative, likes to talk or prefers to do things in his own way with a definite lack of interest in discipline and resents opinions which may be forced upon him. As can be seen these psychological blanks reveal a considerable amount of information regarding the individual. This material was gathered by careful analysis of the blanks, question by question and no total scores were made. The information agrees fairly well with the Rorschach findings but while the Rorschach picture give the basic mechanisms showing how the personality actually works, the other findings point to the resulting trend of activities and interests which the patient manifests in a clinical way. The two supplement each other nicely and together make up a comparative record which can now be compared with the actual clinical picture as observed by the physician in attendance.

The clinical history shows the patient to be a white, single, 20 yr. old male, epileptic, who gives the history of grand mal seizures dating from May, 1939, associated at the beginning with an apparent encephalitic process and continuing about once or twice weekly to the present time. Family history, except for some mild nervousness in the mother, is entirely negative. The personal history shows a normal birth and early development, although the patient, after entering school at the age of 5, was always poor in conduct. He was always somewhat antagonistic to his father, querulous about the home and in early life suffered some inferior feelings because of his small stature. On entering college at 18, however, he had grown considerably and was of slightly larger stature than average. He entered University but did poorly, associated with a "wild" crowd, was markedly extraverted and paid little attention to his studies.

In May, 1939, he developed severe headaches which grew worse, followed by chills and stupor. At a hospital he had repeated convulsions and was diagnosed as a case of encephalitis. He was discharged after 15 days but had a convulsive seizure of the grand mal type on the morning after discharge. He is noted to have become more quarrelsome, irritable, impulsive and egotistical.

Physical examination is essentially negative except for some nasal blurring of the discs, slightly more on the left than on the right. Laboratory findings and x-rays were normal. The mental status on admission showed normal attitude, behavior, stream of mental activity, mental content and orientation. The patient, during his stay in the hospital, was defiant, aggressive and uncooperative. He continued to be quite a problem, engaged in fist fights with the other patients and threatened to strike the nurses. He refused to follow the routine schedule of the ward, was critical of discipline and of the members of the hospital. He easily and readily entered arguments with the other patients and was intensely disliked by the rest of the group. It was necessary to transfer him to a psychiatric ward from the epileptic service and it was during his stay in this ward he had one acute outburst when he became very combative and it was necessary to treat him with continuous sedation.

The personality picture as presented by the physician in charge without knowledge of the Rorschach or psychological findings is as follows:

The patient is impulsive, argumentative, mostly over trivial matters; easily offended and extremely sensitive. He is very quick to respond to any insinuating or suggestively depreciating remarks by others and is aggressive, irritable, emotionally labile, tends to be fault-finding, hypercritical and extremely stubborn. He engages in a fist fight at the slightest provocation.

He is self-centered and egotistical, always insists upon being the leader in various undertakings and is characterized by explosive outbursts of irritability and anger. He is for the most part shiftless, not always to be trusted and deceitful, lazy, lackadaisical, selfish and not particularly interested in aiding others. He is very active in sports which seems to be his chief concern in regard to his illness. In the presence of company he is sociable, pleasant, usually expresses himself in loud terms. He makes friends easily but loses them more easily. He appears rather frank in his opinions, forcibly expresses his ideas and resents any type of authority, particularly parental authority.*

In summarizing this case, then, it can be seen that the three independent studies, the clinical ones made by the physician, the other psychological ones, and the Rorschach are all in comparative agreement. Careful analysis of the Rorschach record reveals most of the findings elucidated by the other two methods and yet its mechanisms are more strictly on a deeper level as for example the longitudinal picture of the intellectual states with evidence of deterioration; the ratios of M; sum C and (Fm + m): (Fc + c + C') and percentage of responses in cards VIII, IX, and X which clearly show the inner attempts at emotional control together with its ineffectual results; and the appearance of signs of organic brain disease not evident by clinical observation; all of which indicate how the individual will react or may be expected to react which is of greatest value clinically, without giving any actual yield of information specifically indicating what his particular interests are. This case presents a manner of analyzing the Rorschach method using a defferential diagnostic technique, and demonstrates the close parallelism of the Rorschach findings with other findings obtained by clinical and other psychological methods.

Case II - Male 20 years, 5 months

Performance		Inquiry
	Card I	
1"	1. Moth, butterfly. You want to know what it is, or what it looks like?	1. It's the whole thing..wings here, and easily could be flapping and flying..but not flying now. There wouldn't be one like this (mentions the 'holes'). Otherwise I have seen moths with their wings ruffed up like this. Looks as if it might be hanging; or pressed into a book. (Whole).
50">VA 1'5"	2. Maybe a leaf. (Returns card).	2. I could shape this; fill in certain spaces; and make a perfect leaf. Even these lines--like the ribs; as if feeding the entire leaf. (Whole).

(Case II Continued)

*(The authors wish to express their deep gratitude to Dr. S. E. Barrera, principal Research Psychiatrist and Dr. B. L. Pacella in charge of the Epileptic service of the New York State Psychiatric Institute and Hospital for their cooperation in this study).

Case II Continued

	Performance		Inquiry
		Card II	
	V	(Turns over immediately).	
5"		This one has me stumped I'd say.	
20"	1.	Same as the other; butterfly, stamped on a page of a book.	1. Seems to have wings, and head protruding out of wings. Butterflies have many colors, though I've never seen one exactly like this. But I've seen large ones with yellow and black. (When asked for detail, cuts off both red spots, the appendage being the head). (Black portion only).
40"	2.	These red spots, I wonder what they represent.	2. And these spots below remind me of larvae where eggs might be stored, only larvae would be this color. (Upper red II).
55"		What do you call these things now? Larvae? It's what they might be. Outside of that they don't represent anything.	Additional a) Like a tilted punching bag. I'd like to knock hard to straighten it up...(demonstrates). (Lower red I). b) And this tail on it like a striped stick of candy, you know. (Projections on lower red). c) These stripes; (in the black) don't know. Might be blood vessels, food passages, food chambers; I wouldn't know.
1'20"		(Returns card).	
		Card III	
8"		These figures all seem the same to me... outline.	Yeh, the same shape.
15"	1.	For all I know these may be icicles, blood around them.	Additional 1. a) I've just noticed something here. The blackness of it..it may even be fur. After cut, these are the scraps, left-over parts. I worked with them. These rough pieces with these pieces could make a scarf. (Lower side black V). (Icicles and blood is outer red II).

(Card III Continued)

Card III Continued

Performance			Inquiry
			(Inner red I).
35"	2.	This one in here may be a butterfly; this red one in the center. Small butterfly; wings and spine down the center.	2. (At this point subject tossed the card onto the pile, turned and looked intently, but blankly at the examiner, made no reply when asked "Are you alright?" Tapped the desk, then put his hands together, wrung them and put his clenched hands onto floor, stiffening as he did so. Shook a little; then in about three minutes spoke, said he was alright, but when asked about the card he was explaining said, "What are we doing with these?" Said he didn't see the 'icicles'. Examiner suggested that he finish the test later, the patient saying, "I think that's a good idea." Then added, "What did they do to me down below?" Examiner left patient in a 'collapsed' mood, promising to return in the afternoon).
1'12"		That's about all I can see. (Returns card).	

Card IV

12"∧∨∧1.		It's all black	
18"∧∨∧		Might be one of these impressions with a pen..pressing ink out to see what image they'll be.	
45"∨	2.	All these seem to have a point at the head.. like two arms and two legs; pushing back.	2. (Difficulty in making a figure).
55"	3.	Or it might be a map.	3. (Develops into Norway). (Lower side light grey III).
1'30"	4.	Looks like a spine running up and down here.	4. (Shows spine through the center).
1'40"	5.	And that slit looks like the rectum.	5. (Uppermost portion 2).
1'55"		These sides look almost like the map of Norway..Shading too.	
2'7"		About all. (Returns card).	

(Case II Continued)

Case II Continued

		Performance	Inquiry
		Card V	
	V	(Turns over immediately).	
5"		Same as all the rest.	
20"	1.	Outside of leaf; impression	1. (Whole).
	2.	made on paper..a butterfly, can't be anything..divided evenly..both sides exactly the same. (Shrugs, with hands upturned in gesture of not knowing.)	2. Butterfly, pressed in book.
1'10"		(Returns card).	
		Card VI	
7"	V 1.	This is more or less what I'd expect bacterias to look like under a microscope. Hair here coming out of a neck.	1. The head here..I've seen that before but I don't know where. Almost seems to be alive, and moving.
40"	∧ 2.	This line here like a spinal column.	2. Spinal column in center. Evenly, in half.
1'10"	∧ 3.	With the top of this, maybe eyes in there. This is darker. (Shakes head, and passes it back)	3. Head has a stinger on it. (Uppermost detail 1)
		Card VII	
15"		(Shakes head).	
	∧V 1.	This might be a design; perhaps.	1. (Design of chair very crudely drawn in).
20"	2.	This might represent a dinosaur.. eyes here..on both sides.	2. (Middle third II).
45"	V	Design of a chair; panel and legs.	(Refers to 1)
55"	3.	Seems to be the design of an elephant; nose of an elephant.. eyes and chest.	3. (Middle third II).
1'20"		(Returns card).	

(Case II Continued)

Case II Continued

		Performance	Inquiry
		Card VIII	
4"	1.	In this one a difference in colors; pinkish-red, blue, grey, rust-color almost like orange.	
20"	2.	Might be an X-ray picture..can see ribs, and spine.	2. (Rib-like figure in upper center V).
45"	3.	Might be an X-ray of a butterfly; I've said that before.	3.
60" ∠	4.	These two figures (snaps fingers to try to recall name) Sort of nose and mouth of a boar. One nose flattened, the other not. Reminds me of a boar, I guess.	4. (Side pink I) Additional a) This pinkish and rust color, as if a rock, and the boar is walking on it, roaming around. Looks to be scenting. (Rocks are lower pink and orange II).
1'5"		Outside of that I see nothing.	
1'15"		(Returns card).	
		Card IX	
4"	1.	I see green here. Very light blue between these two pieces..almost sky color.	1. (Green portion I).
20"		Wonder what I can make of this.	
25"	2.	This up here; this figure might be a tree.	2. (Entire pink portion plus center line V).
50"	3.	This might be a bird, couldn't tell. Looks as if he has one eye, long beak.	3. (Small inner portion at conjunction of green and orange III).
1'15"	4.	Green here reminds me of grass. That's about all I can see there.	4. (darker green near center of card).
1'25"		(Returns card).	

(Case II Continued)

Case II Continued

	Performance	Inquiry
	Card X	
4"	1. Well I still say all these shapes seem to be the same. I see red, green, blue, yellow, grey.	
25"	All of them have rough borders, and all are evenly balanced. All these pictures are evenly balanced.	
55"	2. This thing has so many legs it could be a spider. That's about all.	2. (Outer blue I).
1'10"	3. This could be something put in front of a fire.	3. (Inner green, dark portions only II). Andirons.
	4. Like a rabbit's ears.	4. (Light portion between inner greens rabbit's head VII).
1'30"	5. This might represent a dog, yellow colored, sitting with its head up. That's about all I can see there.	5. (Inner yellow X).
2"	(Returns card).	

Subject said he probably could not remember where he had seen the things when told that he was to locate them. Subject had no difficulty about the responses four hours after the attack. Wanted to know what had happened in the room while he was taking the test. When shown a few 'popular' responses said "I guess you've taught me how to be a closer observer." Was very cooperative.

Case II

Scoring

I.	1.	WS	Fc	A	P
	2.	WS	Fc	Pl	
II.	1.	W	F	A	
	2.	D	CF	AAt	
		D	F	obj.	
		dd	FC	food	
		D	cF	At	
III.	1.	D	CF,cF	icicles & blood	
		D	C'F,cF	Aobj.	
	2.	D	FC	A	P + O-
IV.	1.	W	C'Fn	color	
	2.	W	M-	H	
	3.	D	Fk	Geo	
	4.	D	F	At	
	5.	d	Fc	sex	
V.	1.	W	F-	pl	O-
	2.	W	F	A	P
VI.	1.	W	F-,m	A	
	2.	D	F	At	
	3.	d	F	Ad	

(Scoring Continued)

Case II - Scoring Con't.

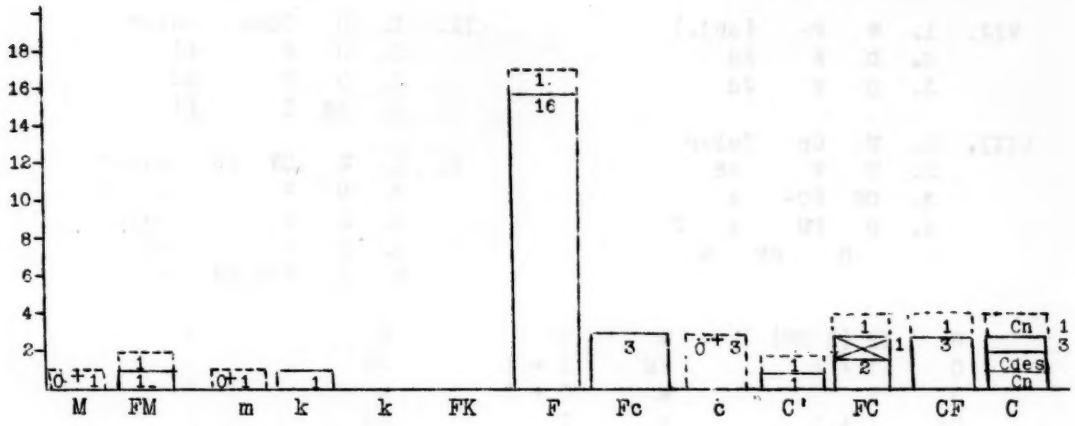
VII.	1.	W	F-	(obj.)
	2.	D	F	Ad
	3.	D	F	Ad

VIII.	1.	W	Cn	Color
	2.	D	F	At
	3.	DW	FC-	A
	4.	D	FM	A P
		D	CF	N

IX.	1.	D	Cdes	color
	2.	D	F	Pl
	3.	D	F	Ad
	4.	dd	C	Pl

X.	1.	W	CF Cn	color
	2.	D	F	A P
	3.	D	F	obj.
	4.	D	F	Ad
	5.	D	F/C,FM	A

W	12 (1 DW)	M	1-	H	1
D	17 + 4	FM	1 + 1	Hd	
d	2	m	0 + 1	A	9
Dd	1 + 1	k	1	Ad	5
S	0 + 2	K		AAt	1
	32	FK		Aobj.	0 + 1
		F	16 + 1 (3-)	At	4 + 1
		Fc	3	obj.	2 + 1
		c	0 + 3	N	0 + 1
		C'	1 + 1	Geo	1
		FC	2 + 1F/C 1	Blood	
		CF	3 + 1	Pl	4
		C	1	food	0 + 1
		Cn	1 + 1	icicles	1
		Cdes	1	& blood	
			32	color	4
					32



37.5% 53.1% 6.25% 3.1%
W D (d) Dd+S

Responses 32
Total time 14' 24"
Average Time per R 27"

Average time up to first response to non-colored cards 11"
Average time up to first response to colored cards 9"

F = 50% (3 F-)

A+Ad = 43%

P = 5 = 16%

0 = 1 and 1 additional 0

(H+A):(Hd+Ad) = 10:5

M: Sum C = 1 : 9

(FM+m) : (Fc+c+C') = 1:4

Cards $\frac{\text{VIII, IX, X}}{\text{R}}$ = 41%

W: M = 12:1

Succession: Fairly orderly

Case II Discussion of the Rorschach Record

Quantitative Analysis

A. Choice of location for interpretation

1. W D (d) Dd + S

Emphasis on wholes. Presence of normal amount of large usual detail, almost enough of small usual detail and normal amount of rare details.

2. Succession fairly orderly. Nothing conspicuous about mental approach from the quantitative aspect.

B. Distribution of determinants

1. One questionable M- response (not in III).

2. One main and one additional FM.

3. One additional m.

This indicates a marked under-emphasis on inner life (See case I for discussion as to what is meant by inner life) FM greater than M,CF greater than FC indicates infantile emotional development.

4. Three F- responses, one M-, one FC-.

Form inaccuracies permeating all the determinants indicates that this is a record which is not within the normal range.

5. Color responses include Cn and pure color. Another sign indicating that this record is not within the normal range. Cn and pure color indicate the presence of primitive emotional reaction patterns.

6. Three Fc, three additional c, one main and one additional C'. This shows a strong desire on the part of the patient for contact with his surroundings, a contact partly limited to the level of physical contact. (Klopfer and Tallman (7)).

The presence of c and especially C' with the lack of inner life, primitivity of color reactions and anxiety represented in k, points to some definite depressive moods in this patient probably resulting in concern with his physical condition.

Hypothesis

Low form level, color naming, lack of positive M strongly indicates a pathological picture.

C. Relationship between factors.

1. Number of responses within normal range (32).
2. Time per response within normal range (27").
3. There is no difference between the average time up to the first response to colored cards as compared to non-colored cards.

4. 53% F but many F-. Hence constriction does not lead to intellectual control. The patient's consciously controlled reactions are poor which indicates mental deterioration or as an alternative manic lack of control.

5. A% is 43. A glance at the content shows that while A and Ad ~~falls~~ below the 50% which would not indicate stereotypy, and while the rest of the content categories make up 50% of the responses three categories (A and Ad, color and at) make up 70% of the content which must be considered as a very narrow range of interests, and ideas. Moreover even within this narrow range we find repetitious content.

6. P% is below average, a finding in schizophrenics, organic cases and neurotics.

7. One main and one additional inaccurate original idea (o-).

8. (H+A): (Hd+Ad) = 10:5 which indicates together with the presence of D and some P, that the subject has some common sense.

9. The Erlebnistypus ratios indicate that this subject is extratensive. All three forumlae point in the same direction (M: sum C=1:9; (FM+m): (Fc+c+C') = 1:4 ; Cards $\frac{\text{VIII, IX, X}}{\text{R}}$ = 41%). The sum of color is much greater than the sum of movement responses and 41% of the responses are to the last three cards.

D. Observations from record

1. Attitude to test

Reading the record shows the strong desire on the part of the subject to do well. This is shown by the fact that in almost every card he doesn't give up a card after one or even two answers but turns it round spending time while he tries in vain to find interpretations (note the turning in card I for 55"; in the other cards the delay between the last response and ~~returning~~ the card; the statements "That's about all I can see" as if to assure the examiner that if he could he would do more).

2. Handling of test situation

In striking contrast to this earnestness on the part of the subject is his inability to handle the situation adequately. We find marked indications of a number of so-called organic signs.

a. Impotence

The subject indicates his helplessness before this situation by asking in Card I, "You want to know what it is, or what it looks like?" He feels that the inkblot must represent something which he is to interpret. In the inquiry he says of his response, "Moth or butterfly. There wouldn't be one like this"(mentions the holes). Yet he allows his response to pass.

Another example of impotence is seen in Card V. Several concepts are confused, the leaf and the butterfly. "Can't be anything". In desperation he turns to a description of the card, it's "divided evenly...both sides exactly the same". But this too doesn't help and he shrugs, 'with hands upturned in gesture of not knowing'. Still he does not withdraw his responses.

b. Perplexity

In Card II the patient says, "These red spots, I wonder what they represent. What do you call these things now? Larvae?" In the inquiry he adds "only larvae would not be this color." The questioning implies that the patient distrusts his own ability and seeks for reassurance, pressing the examiner to decide whether his response is adequate. This attitude implies strong interest in the patient's own achievement. This seeking for assurance for the adequacy of a response occurs within a syndrome in patients with organic brain disease.

c. Repetition

Means the giving of the same response to several inkblots. Once the patient is stimulated by the ink-blot he feels compelled to respond even when his imagination fails him. He can find no appropriate response. Therefore he repeats an old response rather than be silent. Card I is a butterfly and also a leaf. Card II "has him stumped". However he feels compelled to give a response and says, "Same as the other; butterfly". In Card III he says, "These figures all seem the same to me..". Card V "Same as all the rest." In this card he shows his confusion and perseverates with the response "outside of leaf; impression made on paper..a butterfly.. can't be anything". Within card VII he perseverates with the word "design" having used it for the chair and then talks about "design of an elephant". In Card VIII he gives the response "might be an X-ray picture"..and immediately perseverates saying "might be X-ray of a butterfly."

d. The concepts "impression made on paper", "pressed in book" are examples of pet phrases used in indiscriminate fashion. The patient uses them in part to cover his inadequacy in face of the situation.

Qualitative and sequence analysis

1. Form level

Of sixteen responses in which form is the main determinant of the concept, three are poor form and the other thirteen are only outline shapes, without elaborations, on the order of butterfly, spine, etc. We have a similar picture as in the previous record: a "somewhat stable general F level without any brilliant aspects interspersed with some definite F- responses which represents a picture of a partial mental deterioration" (Klopfer 6). Since form inaccuracies occur in the color cards as well as in the non-color cards, it is not likely that the disturbance of intellectual control is purely an extraneous effect due to stimuli from without.

If one examines the rest of the responses it will be found that form inaccuracies or disregard for form play a conspicuous role everywhere. Three responses use crude color as the determinant, three are CF's (form indefinite). In card IV where there is an attempt at movement, the patient shows confusion in giving the form. Hence one can see the general low form level of the responses and one must infer that the deterioration process has progressed considerably. This is born out by the fact that we get glimpses of a previously higher level. In Card VI "what I'd expect bacteria to look like under a microscope" indicates that the patient has the remnants of concepts which are unlikely to occur in a real case of feeblemindedness. Again in card I in spite of his impotence he recognizes that the butterfly which

even people of average intelligence take for granted.."wouldn't be one like this (and mentions the holes)". On the one hand he uses words like "larvae", "dinosaur", "boar" (with some obvious confusion in the application e.g. "larvae and eggs") and makes the keen observation that in the animals in Card VIII "one nose is flattened and the other not". On the other hand, in direct contrast, he gives such very primitive responses as "leaves" to I and V. These variations and the generally low form level leads one to the conclusion that this is not a case of feeblemindedness but of mental deterioration.

2. Movement

Even Card III does not evoke the common human movement response. In Card IV there is an attempt at movement but the form is so confused that it is even doubtful whether this can be called an M-. The presence only of the boar in Card VIII "roaming around", the dog in card X "sitting up" and the very vague additional response in VI "almost seems to be alive, moving" indicates the poverty of inner life even in the area of instinctual impulses.

3. Color

In Card II at the first appearance of color the patient shows that he is strongly affected by it. He even tries to incorporate the color into his response of "butterfly" explaining that he knows butterflies come in many colors, though he has never seen one in this color. However he has trouble in combining the form and color which finally results in his failure to get them together ("I've seen large ones with yellow and black", cuts off both red spots). Now he tries to interpret what "these red spots represent". His fixation to the red stimulus leads to strong intellectual confusion "larvae with eggs".

In Card III he is taken in by the color to such a degree that he develops the very queer concept "icicles with blood around it", the most striking aspect being the strange contradiction in the concept- icicles and blood. This strange contradictory concept seems to reflect a structure in the emotional life where an extreme responsiveness is associated with egocentricity and lack of emotional warmth (icicles in a red spot!).

In Card VIII he responds to the first totally colored card (strong emotional stimulation) with a primitive attempt to avoid giving way to his strong responsiveness (Cn used as a "magic procedure" to avoid being affected by emotional stimulation). Immediately after he tries to escape using color by interpreting the achromatic portion of the card. (He tries to exert conscious control by evasion). However this effort is of little avail since he is so strongly stimulated that he cannot hold back and feels compelled to respond to the color. He is thrown back to the whole ("butterfly") committing the double inaccuracy of a confabulation from xray to xray of a butterfly and a contamination "xray and butterfly" associated with the same material. This strong stimulation expressed in the previous sequence finds expression in one of his two animal movement (FM) responses which represents a release response. He lets himself go and gives way to his instinctual impulses.

Card IX begins as before with a primitive emotional response (Cn) followed by a "weak" FC response followed by an F response which indicates that he can be well behaved at times. However he cannot refrain from going to the extreme in uncontrollable emotional reactions (C). He is swept off his feet by the emotional stimulus.

Card X follows a similar pattern of reaction (Cn,F,F, F/C) established in the other color cards.

To summarize; the patient constantly has trouble in combining form and color. Either he forces a combination by arbitrarily using color (F/c e.g. yellow colored dog in X) or else in the failure to get them together, he overlooks the given form elements and his combinations show gross form inaccuracies (FC- in X). More often he is swept off his feet by the emotional stimulus represented by the color (e.g. C in IX). One notes the discrepancy between the very fine nuances in the color naming and the crudeness with which he uses color in his responses. He struggles with his strong responsiveness by attempts at evasion or control, ending either in an emotional explosion (violence) or occasionally in a release of instinctual drives.

Shading

The patient comments on the "wings ruffled up" and the "leaf" with the "ribs in it" (Card I); "stripes in black- blood vessels..." in Card II; "these rough pieces with these pieces here could make a scarf.. it might be fur" in card III; rectum in card IV. He also shows his sensitiveness to shading in Card IV in the geography answer. Many of these responses indicate sheer sensitivity without use or purpose in a concrete situation because of the disregard of the form. This would indicate in this particular picture general undifferentiated sensitivity.

Summary of personality description

Emotional aspect

The two striking occurrences in this record are the attempt at constriction which however is unsuccessful (F-) and the affect that comes to expression (CF and Cn) which points to egocentricity and direct aggressive reactions. The patient's attitude to the colored spots is assumed to correspond to the emotional attitude to the environment. This patient shows great effort but little success in emotional adjustment because of uncontrolled and unintegrated forces within the personality and primitive forms of satisfaction.

The patient is likely to give vent to strong, labile, egocentric affectivity (blood and Cn). He seems to be a rather helpless victim of his emotions because "He does not have a strong inner life into which he could withdraw in a crisis" (Klopfer 6). (He is strongly stimulated, has no inner life, makes attempts at control in which he is not successful and hence is helpless). The poorly developed inner life and the very labile emotionality must make the patient tense, touchy and consequently he must be very frequently tempted to act in an impulsive, imprudent manner.

The erlebnistypus is greater on the color side. Hence he is preoccupied with his relationships to the outside world. The patient can therefore be considered extroversive. He is very sensitive (c). However this sensitivity is undifferentiated and unrestrained, not integrated into the personality as a form of control.

Since he is highly sensitive to outside stimulation he is likely to be irritable often without specific cause - just a general irritability. This sensitization is also reflected in the c and C' responses and in view of the lack of inner life as a sanctuary the patient is apt to present depressive

periods coupled with anxiety concerning himself in relationship to his surroundings associated with self-depreciative feelings and possibly hypochondriacal complaints. His aggression indeed may be turned inward producing even more profound depressive reactions.

Intellectual aspect

1. In spite of some indications of a previously higher level of education and thinking, the intellectual efficiency is below the level of the healthy individual. (Form level).

2. There are no M's.

3. The quality of whole responses: three are sheer color naming, three are F- responses,one is a DW (VIII), one (I 2) while not really inaccurate represents a rather childish and primitive response which certainly does not deserve the fuss he makes about it, one is an M- (IV) because of the difficulty on the part of the patient in getting a human figure and only three are just average (I 1, II 1, V 2).

The lack of M and the poor quality of whole responses shows his intellectual life will be unproductive and ineffective in the realm of abstract thinking. But the orderly succession and the normal amount of big D indicate that within a concrete area of dealing with the problems of every day life he may still function within the normal range.

The overemphasis on whole responses is an indication that he is not aware of the limits drawn by his deterioration and his aims and goals are not within the area of attainment.

Differential diagnosis

In this patient the signposts pointing to organic brain damage are somewhat more apparent than in Case I. His responses however in the aggregate depict a personality pattern similar to Case I. Schizophrenia, manic-depressive psychosis, psychoneurosis and mental deficiency can all be easily ruled out by the reasoning outlined in the preceding case. Here again then we are faced with a possible organic showing a so-called epileptic personality pattern. Harrower-Erickson (3) has shown that focal epileptics do not present this pattern such as described by Rorschach, (12) Stauder, (13) and Guirdham (2). Further it seems reasonable to conclude that such a record developing in a case of definite organic brain damage would show more evident signs of specific organic brain disease. The final impression based exclusively on the Rorschach findings is Convulsive state- probably ideopathic type.

Clinical Discussion

Case II.

This patient was also given the same psychological tests and his findings are as follows:

His score on the revised Stanford Binet, form L, was 16 yrs., 5 mos., with an I.Q. 1f 112. He showed a much more active emotional state, became very easily upset and tense and this probably accounts for his poor performance on the Ferguson Form boards which showed him in the 20th percentile of adults.He, however, had no difficulty in grasping the real principles of

construction. His judgment for personal economics, family and community relationships and social, civic problems can be said to be adequate and within normal limits. As regards interests and activities he is considerably more well rounded than the previous case and yet specifically prefers those activities of an extraverted type, such as "vocal expression, social activity, commercial activity, music, scientific work and outdoor activity." He has some creative imagination, although it is limited to singing or speaking, or writing, on an average level. His occupational interests are varied but on the whole are definitely in the extraverted group such as "Reporter, social worker, editor, clergyman, council, college professor, cartoonist, actor, etc." As regards activity, he is also interested in extraverted types such as "Making speeches, organizing plays, opening conversation with strangers, meeting and directing people, meeting new situations, writing reports, entertaining others, expressing judgment publicly, regardless of criticism, being pitted against another as in a political or athletic race, continually changing activity, etc." As regards peculiarities of people he shows a very large number of dislikes and apparently is disinterested in abnormal type which is an expected finding in view of his apparent inferior feeling regarding his own personal disability. On the whole, these blanks show a predominant, extraversial trend in activity, interests and vocational life.

As regards personality and adjustment, this patient is considerably different from the preceding one. He is filled with numerous somatic complaints and undoubtedly often manifests a considerable number of hypochondriacal trends. He shows considerable inner agitation and depressive responses, such as, he considers himself a nervous person." He is often sorry for things he does, frequently has spells of dizziness, envies the happiness of others, feels a lack of real affection and love in his home, frequently feels blue and depressed, gets upset easily, finds it necessary to watch his health carefully, worries too long over humiliating experiences, and feels that his parents do not understand him." He also manifests a certain definite amount of extraversial, egocentric reaction," trying to get his own way, even when he fights for it, frequently feeling grouchy, dislikes work which may take him into isolation, prefers to do his own planning, experiences many unpleasant moods and feels able to face his own problems." On the other hand he also shows a considerable amount of lack of self-confidence, low spirits and depressive trends.

From these studies, then, we can conclude that this patient is slightly above average in intelligence, but is more easily affected by external situations, that his judgment is still good, but that he shows extraverted, egocentric and occasionally irritable or querulous reaction. In addition, he has numerous hypochondriacal complaints and definite depressive, self-depreciatory trends.

The clinical history shows the patient to be a white, male, age 20, who has had attacks since March, 1933, when he was 13. Family history is essentially negative, except for mild nervousness in the mother and a suicide of a paternal aunt. Little is known about the early history, although at the age of 6 the patient was struck in the forehead with a broken bottle, but with apparently no other result than a scar. He was a severe thumbsucker until the age of 10, following which he developed masturbatory activity. The first epileptiform seizure, which was generalized in nature, occured in 1933 and was considered to be due to excess masturbation. The patient continued through high school but left during the third year because of extreme sensitivity to social ostracism because of his attacks.

Physical examination, except for acne, a cardiac systolic murmur, is essentially negative. Laboratory findings and x-ray studies are essentially normal. Mental examination, upon entry, showed normal stream of talk, orientation, attitudes, etc. The patient, however, has definite hypochondriacal complaints and shows certain depressive trends and manifestations. The patient frequently exhibits spells of irritability when he becomes argumentative with other members of the group. As a rule, however, he is friendly, congenial, enjoys singing loudly on the ward and is cooperative to routine activity. The following is a personality picture as presented by his physician, again without knowledge of the Rorschach or other psychological findings.

The patient is friendly, sociable, pleasant and highly sensitive and as a rule, quite active in various activities, enjoying sports. He often shows mood swings and becomes quiet, depressed and rather pessimistic as to the future. He is the easily discouraged and worrisome type. He enjoys conversations, particularly with the opposite sex. He talks freely of his difficulties which to him appear to be mostly sexual in nature. He shows some tendency to hypochondriasis, and often looks at himself in a mirror and has expressed the idea that his eyelashes are too long and tend to give him an effeminate appearance. For the most part, however, he is rather practical in his outlook. He uses tools to good advantage. He has been interested in sports and has attempted to write poetry and even music and enjoys singing. He is not particularly bashful with strangers and is generous, trustful, and adapts himself fairly well to new situations. He tends to be over conscientious in performance of his work. He is rather finicky about his food. He frequently compares himself with other individuals, disparaging his own attributes and character. Has frequent spells of anxiety and often shows a tendency to self-depreciation and is very sensitive to failure or success of any project which he undertakes. He enjoys presents and attention of others. He is neat and tidy in his personal habits.

This case, like the previous one, shows a remarkably close correlation between the clinical and other psychological findings and those revealed in the Rorschach method particularly in the personality descriptions. The Rorschach findings reveal an impending deterioration not yet demonstrable in the intelligence tests.

Both cases are clear cut clinical cases of grand mal epileptic attacks and both cases are similar in their personality pattern. As can be seen, however, both cases manifest marked differences in personality reaction and these reactions are accurately mirrored in the Rorschach responses. These two cases are clinically typical examples of the idiopathic convulsive state and give response patterns similar to those described by Rorschach, Stauder and Guirdham. They are obviously not of the focal epileptic type and consequently would not necessarily be expected to reveal a great number of organic signs. It can be seen, however, that some of these organic signs are definitely present in each case, qualitatively modified. The diagnosis is not made by tabular methods, but rather by constructing the whole personality pattern which is revealed to be typical of the epileptic pattern and which cannot be fitted into any other type of mental abberation.

Summary

1. Two Rorschach records of known cases of Idiopathic convulsive States are presented together with pertinent clinical and other psychological findings.

2. The use of a clinical differential-diagnostic technique permits the diagnosis to be made from the Rorschach findings of convulsive states-probably Idiopathic.

3. Through the Rorschach method a complete clinical picture is established and even more important the basic operative mechanisms are elucidated so that future behavioristic manifestations can be satisfactorily predicted in these cases.

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